Barchester Healthcare Homes Limited

Westergate House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 2 June 2015 and was an unannounced inspection.

Westergate House provides accommodation and nursing care for up to 76 people. The home is set in gardens and consists of a main house connected to a newer building, known as the annex. The annex, is home to the 'memory lane community' which cares for people living with dementia. At the time of our visit there were 68 people living at the service. The home also offers respite care.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Where people lacked capacity to make decisions, records did not clearly evidence the process that had been followed. As a result the service was unable to

Summary of findings

demonstrate that people's rights under the Mental Capacity Act had been respected. Where people may have been deprived of their liberty, proper processes had been followed that met the requirements of the Deprivation of Liberty Safeguards.

There was a sense of community at the home, complete with three dogs as people were able to move to the home with their pets. There was a regular staff team who knew people well. New employees spent a minimum of two weeks shadowing experienced staff so that they could get to know people and the service opted for their own staff working additional shifts rather than using agency staff. One staff member said, "Staff are good, care is good, and teamwork is good. We are working our level best for the residents here".

People felt safe at the home. One said, "My daughter and son think it is lovely here too. They don't worry about me, they know I'm happy here". Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely and at the right time.

Staff received training and support to deliver effective care to people. Every member of staff working at the home had attended dementia awareness training. The home had its own trainer who was rolling out a further eight week programme to staff. Staff felt supported and were able to approach their seniors for advice or guidance. There was a system of supervision and appraisal in place where staff could discuss professional development and training needs.

The service was caring. Staff were available and were quick to anticipate people's needs and wishes. Staff engaged with people on an individual basis. They shared positive relationships, based on friendship and respect.

Mealtimes were a sociable experience and people spoke highly of the food. The chef provided a choice of menu and was clear on people's dietary needs and preferences. People received support and staff ensured that they received enough to eat and drink.

People were involved in planning their care and were supported to be as independent as they were able. Where there were changes in people's needs, prompt action was taken to ensure that they received appropriate support. This included the involvement of healthcare professionals, such as the GP, Dietician, Community Psychiatric Nurse (CPN) or Tissue Viability Nurse (TVN).

The home was well-led. The registered manager had a system to monitor and review the quality of care delivered and was supported by monthly visits from a representative of the provider. The registered manager received regular feedback from people, their relatives, staff and visitors. They took prompt action to address any concerns. Where improvements had been identified, action plans were in place and used effectively

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

Where people lacked the capacity to give their consent, their rights may not have been protected. The registered manager was unable to demonstrate that the Mental Capacity Act 2005 (MCA) had been followed because capacity assessments and best interest decisions were not documented.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received regular supervision and appraisal.

All staff had attended training in dementia care and were continuing with an advanced course.

People were offered a choice of nutritious food and drink.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from regular staff who knew them well and cared about them.

People were involved in making decisions relating to their care and encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

Staff engaged with people and offered both individual and group activity according to people's interests.

Summary of findings

People were able to share their experiences and any concerns were quickly addressed.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt involved in the running of the service and able to share ideas or concerns with the management.

Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager and provider used a series of audits and unannounced checks to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Westergate House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 June 2015 and was unannounced.

Two inspectors, a nurse specialist advisor and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed two previous inspection reports and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We observed care and spoke with people, their relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for eight people, seven staff files, staff training and supervision records, medication administration records (MAR), monitoring records for food, fluid and people's weights, quality feedback surveys, accident and incident records, staff handover records, activity records, complaints, audits, minutes of meetings and staff rotas.

During our inspection, we spoke with 16 people using the service, four relatives, the registered manager, the head of care, four registered nurses, six care staff, an activity coordinator, the chef, the home's trainer and a representative of the provider who was visiting. Following the inspection, we contacted professionals to ask for their views and experiences. These included a hospice clinical nurse specialist and a community psychiatric nurse (CPN) who had involvement with the service. They consented to share their views in this report.

Westergate House was last inspected in February 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us that they felt safe. One said, "I'm more than safe, they take total responsibility". Safeguarding was discussed at interview with potential employees and following this all staff completed safeguarding training at induction prior to working with people. The home trainer told us they delivered safeguarding training as a workshop during the first two days of induction training and this was followed up annually through observed practice and knowledge checks using scenarios and questions. The training records showed that 94 percent of staff had completed safeguarding training. Staff files contained examples of completed training, observations of staff practice and questionnaires as described. Staff were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member told us, "Abuse can be verbal, physical, physiological, emotional and financial. I have not had to raise a concern but if I did I would speak to the head of care, a nurse or the manager". Another said, "The managers would definitely act".

We looked at the records of safeguarding alerts raised by the registered manager with the local authority safeguarding team. The registered manager had taken appropriate steps to report concerns and had taken action to reduce the risk of harm to people who used the service. The registered manager said, "Where people in the memory lane communities are unable to verbalise their concerns the staff are the eyes and ears to support residents, I encourage residents to speak freely". We noted that one alert had been raised following feedback from a resident about a staff member. Following investigation the staff member was no longer working at the service. One staff member who had reported a concern told us, "She (the nurse on duty) absolutely took me seriously. She validated me".

Risks to people's health and safety were assessed prior to admission and were regularly reviewed. A relative told us, "It's a relief to have her here. She was very independent, and a bit stubborn, but we did worry about her safety at home. We have complete confidence in the staff here". We saw examples of assessments on how to mitigate the risk of falling, choking and the development of pressure areas. Consideration had also been given as to how staff would support people who were unable to use a call bell to alert staff that they needed assistance. Action had been taken to monitor and mitigate risks. For example, some people at risk of skin breakdown used an alternating pressure mattress and were supported to change their position on a regular basis. One person who had moved to the home with a pressure ulcer was thrilled with the healing progress since they moved to the home. They told us that the ulcer was not healing before admission and that the size had reduced significantly as a result of the care that they had received. Records of falls included the time and location of the fall so that any trends could be identified in order to mitigate future risk. One staff member told us, "We write about accidents and incidents and the nurses look at this and then discuss it with us". We observed staff following guidelines to reduce the risks to people. For example, by prompting a person who was unsteady to use a walking frame and fetching it for them.

Where people had presented with behaviour that might put them or others at risk, monitoring was in place. One staff member told us, "Some people do get aggressive with each other, I have managed till now by talking, giving a cup of tea, engaging people in games or going outside in the garden. I have had training on this here". We observed another staff member using diversion techniques to prevent a situation between two people from escalating. The carer approached the person, gained eye contact, touched her hands then gently led her to another area, saying to her "Shall we go and have coffee together?" She then stayed with her until she was calm. Behaviour monitoring information had been used to identify patterns and triggers. This demonstrated that people's needs were monitored and reassessed on a regular basis to ensure that they were receiving appropriate care.

During our visit we observed that staff were available and were able to anticipate and respond to people's needs. Staff were present in communal areas and responded promptly to call bells. One person told us, "I'm safe, even though I can't do much for myself now. When I ring, they're pretty quick to come". The registered manager had recently introduced a dependency assessment in order to ensure that the staffing levels were appropriate. The home had a policy of not using agency staff. One nurse told us that not using agency staff helped them to manage behaviours that challenge. They told us, "Permanent staff work extra hours when needed and this gives continuity of care". Staff told us there had been a shortfall in staff and that they often

Good

Is the service safe?

worked with fewer carers than scheduled. Staff rotas covering an eight week period confirmed this showing that shifts had often fallen short by one carer on each unit during the day and by one nurse and one care staff during the night. The registered manager said "It's not ideal when we work on reduced numbers but the consistency is important, I can say wholeheartedly that we are adequately staffed and when we have the full complement we are over staffed".

The registered manager described other arrangements they had put in place to ensure people's needs were met when staff numbers were reduced. This included the head of care working an additional day, activities and housekeeping staff supporting people with care (where trained) and support from the registered manager. Staff we spoke with confirmed that additional support was available from managers when required. One staff member told us, "They're losing staff because it is hard work. It isn't unsafe but it is hard work". Another said, "They (managers) are looking to improve the quality of care by employing more staff; they try to ensure we give proper care and that we follow routines. The heads of unit visit us every day to make sure it's alright here". In addition to nursing and care staff, the home employed activity, kitchen, housekeeping, garden, maintenance and administration staff. This meant that nursing and care staff were able to focus on supporting people.

The registered manager told us they had now recruited to almost all vacancies, with just four posts remaining. We noted that a recruitment open day was planned. Staff also confirmed they were seeing improvements in staff numbers. Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers and their qualifications were checked in line with information supplied on the application form. This helped to ensure that new staff were safe to work with adults at risk.

People received their medicines safely. Medicines were administered by nurses who told us that their competency in medicines administration had been observed and checked. We observed part of the medicines round during the morning. The nurses checked the medication, the dose, frequency, that they were administering it to the correct person and the expiry date. They also provided clear information for people regarding their medicines and administered them in accordance with the instructions from the prescribing GP. Medicines, including controlled drugs (controlled drugs are drugs which are liable to abuse and misuse and are controlled by legislation), were stored safely and accurately recorded. Guidance was available for 'as needed' (PRN) medicines and, when given, staff had noted the reason for administration. PRN medication for pain relief was offered. Where this was given, the nurse checked later that this had been effective and updated the records. Records for the administration and disposal of medicines were complete and up-to-date.

Requires Improvement

Is the service effective?

Our findings

Staff supported people to make decisions. They understood the principles of the Mental Capacity Act 2005 (MCA) and how people's consent should be sought. We found, however, that there was limited recording of how people's capacity had been assessed or how best interest decisions had been made.

Mental capacity refers to a person's ability to make a specific decision at the time when it needs to be made. The provider's policy on mental capacity stated that, 'Where the Home has information that suggests a person might be unable to take some decisions at some times, it will carry out an assessment of that person's mental capacity'. We were unable to find evidence of capacity assessments in people's records. Some people used bedrails to prevent them from falling out of bed, others had been given a flu vaccination and one person was administered their medication covertly in a drink. If a person was unable to make or contribute to these decisions, their capacity should have been assessed and, in the case where they were found to lack capacity, a best interest decision made on their behalf. Best interest meetings should be convened where a person lacks capacity to make a particular decision, relevant professionals and relatives invited and a best interest decision taken on a person's behalf. We saw that some decisions had been made by relatives, such as to consent to a flu vaccination, however, in the absence of a lasting power of attorney a relative does not have a legal basis to make decisions about healthcare and medical treatment. Speaking about the use of bedrails, one nurse told us, "We write about it in the progress and evaluation notes but there isn't a protocol to follow that I know of". Care records referred to best interest decisions but lacked evidence to demonstrate that correct processes had been followed.

The registered manager was unable to demonstrate that assessments have been carried out in line with the MCA and that people's rights have been protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager informed us that the provider was reviewing its care plan documentation and that incorporating capacity assessments and evidence of following the MCA was being looked at. Staff had attended training in the MCA and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated an understanding of the principles. One said, "We are making decisions in people's best interests when they don't have mental capacity, such as using information in the care plans about their likes and dislikes". Another staff member said, "If they can't make a decision we try and let them choose and help them to choose. If not we think of the option that's best for them and the least restrictive". Staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waiting for a response before acting on their wishes. One staff member said, "Whenever I am with people I make sure they have a choice and they have what they want and how they want it. I make sure the care is for them. They really appreciate options and we are really practising this". Another told us, "If care is refused I come back later or I send a colleague, I try to encourage people sometimes I get the head of care as she has a lovely talent to talk to and settle people". People told us that they could choose what time they got up, when they liked to have breakfast, and when they preferred to go to bed.

The provider was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'. We saw that applications had been submitted to the local authority. The home had received decisions to authorise DoLS on six applications from the local authority.

People had confidence in the staff supporting them. One said, "We are looked after very well". A friend of one person said, "I couldn't fault it here. She has constant care". The home had its own trainer who worked full-time. Staff spoke highly of the training they had received. One told us, "Its good quality training. The home trainer is really good at keeping us up to date. If it's not provided here she looks for it in other places we can go". Another told us, "For training, they are a really good company" and said, "Before training was a problem now we have it nearly every week, the home trainer has really built it up".

The home trainer showed us the system used to monitor the on-going training needs of staff. This included information from supervision sessions where development needs were identified. Training made mandatory by the provider included emergency first aid, customer care, fire, food safety, health and safety, infection control, moving

Is the service effective?

and handling and safeguarding. At the time of our visit 93 percent of staff had completed this training. The home trainer told us staff were able to go on to complete health and social care qualifications once they had completed induction. One staff member who had a health and social care diploma at level 3 said, "The training is good and I am now doing the care practitioner course". Training records showed that staff had attended additional training to develop their skills and meet the needs of the people they supported. Titles of additional courses included; explaining restraint, the use of bedrails, dealing with violent and aggressive behaviour and ski-pad training (used in fire evacuation).

All staff working in the home had completed a six-hour dementia awareness training course. A further advanced programme was being rolled out to all staff to develop their knowledge and skills. This programme comprised eight trainer-led sessions aimed at promoting person-centred and relationship focused care for people living with dementia. Staff were enthusiastic about the training. One nurse told us, "I didn't have a dementia background so the course is helping a lot". Another described how they supported a person who became anxious, "I have a nice walk with them and get some fresh air, we have tea and cake and I look at photos of their family". The registered manager told us how it was important all staff had an awareness of the needs of people with dementia, "Whether that's a staff member delivering care or a maintenance person walking through the unit". A Community Psychiatric Nurse (CPN) who worked with people using the service told us, "The amount of training they do is phenomenal and it shows in the care. You can see it, it hits you in the face".

New care staff completed a 12 week induction programme based on the Common Induction Standards and incorporating the new Care Certificate. Staff were assigned a mentor who was responsible for assessing and verifying their competence throughout. Staff were not able to work alone until their induction had been satisfactorily signed off. Staff told us that they had shadowed experienced staff for a minimum of two weeks. One said, "I spent the first week training, then two full weeks shadowing. It gives you a chance to get to know each resident". The induction for nursing staff included clinical practice and training. We looked at examples of completed induction workbooks and saw induction had been completed satisfactorily. One of the newest nurses told us that they had worked for four weeks on a supernumerary basis shadowing an experienced nurse.

Staff felt supported by their managers. One said, "We can approach the head of care and the manager at any time and we can discuss any concerns with the head of units". Staff received supervision and an annual appraisal. Records indicated that staff supervision had fallen behind the provider's plan of six per year for some staff. The registered manager had taken action to address this and we saw that almost all staff had attended supervision in April 2015.

The registered manager ensured that the registration of nurses working in the home was current. Nurses had attended update training in venepuncture and had been trained in the use of syringe drivers. The head of care shared learning from quarterly meetings run by the provider; the most recent had been on the use of thickeners in fluids. Three nurses told us that they would like to follow post registration training in tissue viability or palliative care. A hospice specialist nurse also suggested that specialist training in palliative care would benefit people and staff. There was currently no formal post-registration training in palliative care delivered by the provider, although the trainer advised that this would be provided if requested via supervision. One nurse told us, "They're happy to train people up as much as they want to be trained".

People were very happy with the food served at the home. One told us, "The food is so good, I've put weight on!" Information about people's dietary needs, likes and dislikes was clearly recorded. Any changes were updated and shared with the chef on a monthly basis. Information included needs such as thick puree, fork mashable, high calorie, gluten free, vegetarian and low fat diets. The chef had attended training in dysphagia (problems with swallowing) and understood how to prepare meals of varying texture. People were offered a choice of food. The day's menu was on display. For those that could not choose from the menu, we observed that they were given a visual choice of meals to select from. The food looked and smelt nice, and was served hot and fresh. It was enjoyed by the residents, and there was not much waste. The chef said, "It's all home-made, even the bread. We do everything we can to cater for every fine detail". Lunch was a sociable

Is the service effective?

occasion. Staff served each individual addressing them by their first names and provided the combinations of food that were requested, offering more to anyone who wanted some.

Where people were at risk of malnutrition or dehydration, steps had been taken to ensure that their intake was monitored and that they received appropriate support. We observed staff encouraging people to drink. Fluid charts were maintained and used effectively. One staff member said, "They keep on top of it. Any concerns are shared in handover". People were weighed on a monthly basis, or more frequently if concerns had been identified. One person told us, "I usually have my food up here (in their room) by choice. I enjoy my porridge and toast in the morning, but my appetite is less than it used to be. But they'll get me anything I fancy, and I get weighed regularly, I don't feel thin!" The registered manager reviewed people's weights each month and checked for weight loss or gain in the last month and over the past six months. There was also a bi-monthly nutritional meeting which looked at the menu, people's weight loss and gains, food allergens, hydration and support for residents who required assistance with eating and drinking. Action had been taken to address concerns. Some people had been referred to the dietician for advice, others were offered a fortified diet. A friend of a person who had lost weight told us, "They give her a smoothie at coffee time, they are on top of it".

People had access to healthcare professionals. One person told us, "If we need a doctor, we get one, I've no grumbles". In people's care records we saw that timely and appropriate referrals had been made. These included to the GP, CPN, dietician and tissue viability nurse. A CPN who worked with the service told us, "They listen. They listen to professionals and they like liaising with all the different services". They told us about one person who presented on occasion with behaviour that could be described as challenging. They had helped to settle this person in the home and said, "They managed it (the behaviour). I was amazed. We worked hard with them".

Good

Is the service caring?

Our findings

People spoke enthusiastically about the home and staff. One said, "They are always asking me if they can do anything for me. I don't mind how long I live here!" We observed that people had a good relationship with the staff who supported them and it was clear that staff knew people well. One staff member who was mentoring a new member of care staff explained that new staff shadowed for a minimum of two weeks. They told us, "It takes time to know the residents". The home was proud that it had a regular staff team and spoke of the benefits this brought to people through providing good continuity. The home had received positive recommendations on the carehome.co.uk website. Recommendations submitted over the last two years had resulted in a score of 9.3/10. One relative had written, 'The understanding of their needs and respect for their individuality is at the forefront of their care. We will always be grateful for the genuine affection and compassion of the staff, which seem boundless!'

During our visit we observed staff laughing and interacting with people. They were attentive and were able to anticipate people's needs. There was a variety of activities in the lounges; staff reading the paper with one person, putting words on a Scrabble board with another, singing along to music with a small group and chatting to others. Care plans included information about people's lives and interests. Staff were able to tell us about people. Speaking about one person they said, "She is a very good singer, she likes to read books and is very chatty and gives a good massage. Sometimes she can walk but she has a history of falls so we use a wheelchair to go to the dining room". They told us that another person was upset by conversation about the war and that this was best avoided. The home was recognised by the Cinnamon Trust as a pet friendly home. At the time of our visit there were three dogs in residence. One person told us, The staff are nice, you get your own way! I like the dogs, they're lovely the dogs". Staff spent time with people who could not communicate verbally. We joined a staff member as they spoke with a person in their room. The person liked classical music and this was playing quietly. The person reacted by making small sounds. Staff explained how another person was quite unwell on admission and had so far preferred to stay in their room. They showed understanding of the situation and empathy. One staff member told us, "The staff have good character. That's important. You can't train in that".

People were involved in determining their care and support. Care plans included details about how people communicated and described their preferences. In one we read, 'Doesn't like to get up too early. She likes to wake up naturally in the morning'. In another, 'Likes to sit at the table with other people'. Each person had a named nurse and keyworker. One staff member told us, "I have got three people I keywork so I need to spend time with each person every day. I talk to them about their interests or family or I do an activity such as nail care and tidy up their wardrobe. We are allocated time for this in the mornings". Where they were able, people had signed their care plans to demonstrate agreement. People made choices as to where they spent their time and whether or not they participated in activities. One person told us, "Sometimes I have lunch in my room; sometimes in the dining room, depends how I feel". One person was due to go out with a relative. The nurse discussed with the person as to whether they would walk or take a wheelchair. The person made the choice to walk and put the wheelchair in the car in case it was needed.

Staff supported people to be as independent as possible. At lunch time we observed a carer sitting with a lady who had a tremor in her hands. The carer chatted to her, only helping with her cutlery when necessary, encouraging independence. A staff member told us about one person saying, "She is a very nice lady. She chooses her clothing as we go through them. We are supporting her to be independent. She was using a hoist following a fall and with our help little by little she is able to walk with a Zimmer and one carer". Care plans included information as to tasks people could manage independently. We read, 'Is able to wash and dry her hands and face if given a flannel with the assistance of one carer' and, '(Person) has her own teeth, she is able to brush them but needs help with the toothpaste'.

People told us that they were treated with respect. We attended a daily meeting of staff. People were referred to by name and their needs were discussed in a caring way. Staff took care to help people maintain their dignity. Care plans included information on how people liked to dress. After mid-morning tea and biscuits we saw a staff member wiping a lady's hands and she seemed pleased with this. Another person was asked, 'Can I pop this (clothes protector) over the top of your blouse because it's so pretty, I don't want to get it mucky'. Speaking about one person who had recently started to use a hoist, a staff member told

Good

Is the service caring?

us that they liked to wear skirts and that they used a blanket to cover their legs and shielded the person from view by positioning themselves accordingly. When people received visitors staff welcomed them. One person said, “They’ve just brought us some tea, and look how nicely it’s served!” A comment on the recommendations website read, ‘Westergate House stands out as the type of care home you would want someone you care about to be looked after. In the dementia unit the residents are treated with such respect and in a dignified manner’.

Good

Is the service responsive?

Our findings

Staff knew people well and understood how they liked to be supported. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. One person told us, "The carers are very good, very nice staff, and I need a fair bit of help. They discuss my care with me, and with my daughter. I used to paint, and they encourage me to carry on, and I've got a (model) boat over there I'm still working on". Another told us, "It is very good, here. Staff are very nice, they don't make a big thing out of anything". People's care records were individualised. They included details such as the brand of shower product the person liked and specific information such as that a person, 'Feels the cold'. We noted that this person had warm slippers on and a blanket as they relaxed in the lounge. One person who had moved to the home with their dog was sitting in the lounge with the dog, holding its lead. A CPN who worked with the service told us, "Everything is done on an individual basis. They give them options".

Each person had a care plan describing how staff should meet their needs. These were reviewed on at least a monthly basis. A summary of the review was included along with information on any sections that had been updated. One staff member told us, "The care plan gives you a good history, it's about them as well as their medical needs, it gives the bigger picture". Another said, "I can go straight to the care plan and look". The reviews were effective. One person was prescribed two pain relief medicines and needed the maximum dose of each. The nurse had requested a review from the GP. For another person the nurse had queried a prescription for a strong pain relief medication as they were concerned it may increase the person's risk of falls. The GP had reviewed the medicines and removed it. Care staff recognised when people were not so well and reported this to the nurse, this was documented in the daily records. One staff member told us, "The manager and head of care really help you as much as they can. It's really good if we ask for anything the residents need it's there as soon as possible".

Group and individual activities were available to people. Throughout our visit there was a variety of activity and staff regularly engaged with people. For example as a staff member was serving drinks they stopped to speak with a person who was reading the paper, asking, "Is there any good news today?" Two staff were holding an impromptu music and dance session using CDs of swing music to help some people living with dementia enjoy the rhythm and movements, and singing along. A jigsaw on a tray was part-completed, with people being invited to add a few pieces whenever they felt like it. There was clear enjoyment and engagement. One person told us, "We get talks about once a month; there are church services here too". Their neighbour added "And musicians. We can do anything we want! I like laughs with my friends, and we get old films, quizzes, ball games". People told us that the home could arrange taxis or a minibus for outings. The friend of one person told us, "They're always doing something" and added, "When it was nice weather they were outside, sitting in the sunshine".

The home employed three activity staff, one working in each part of the home. As part of the monthly review of care, people's activity preferences and engagement was considered. The newly appointed activity coordinator told us, "I'm keen to sit down with my colleagues and discuss new ideas. I'm in favour of written plans for people, and progress notes; likes and dislikes; all that, so you can build on what they like to do". One person who preferred to stay in their room told us, "I know there are activities and crafts I can do if I wish. They come up with a sheet of them, every week, but I like my own company, so I don't choose to do much of those. I'm perfectly happy with my TV and my books".

The home had considered the needs of people living with dementia. The communal areas were spacious providing a choice of areas in which to relax. The walls were brightly painted and there were objects such as a hat stand, complete with hats and a feather boa, kitchen spoons and utensils hanging from a shelf near to the kitchenette and a sensory area with fibre optics and different textiles. Tea and coffee were served in brightly coloured cups and light switches were of contrasting colour, which can help some people if they have difficulties with visual perception. In the upstairs part of the home people were able to walk in a circuit, which was clearly enjoyed by some. There was a barber shop which had a red and white pole on the wall outside which would provide a visual prompt. The CPN we spoke with said, "What I like is that they aren't medication

Good

Is the service responsive?

orientated. They work through it with us". Staff were skilful in supporting people living with dementia. They provided activity, stimulation and reassurance in accordance with people's needs.

People and their relatives were involved in the running of the service. The registered manager and staff engaged with people on a one to one basis. People felt able to raise concerns. We asked if they would know who to speak to if they had any worries. One said, "Oh yes, I'd talk to the carers, and I would if I needed to!" Another told us, "If you ever have any worries, there's always a listening ear; there's nothing I'd change". Formal opportunities for feedback were also available in the form of resident and relative meetings. An annual survey coordinated by an external company had been returned in 2015. This demonstrated that the home had responded to feedback from people using the service. For example, in response to concerns over the laundry service, a member of housekeeping staff had spent two days at another service run by the provider to observe practices. A labelling system was also introduced and the subject was discussed at a residents' meeting. The latest survey showed improvement in each category; 'Staff and care, home comforts, choice and having a say, quality of life'.

The provider had a complaints policy which was clearly displayed. We saw that the few complaints received had been dealt with appropriately and in accordance with the timescales set out in the policy. People told us that they had not had cause to complain. One said, "The staff are all very nice. I'm fussy, so I'd complain if I needed to!" A member of staff told us, "It's quite relaxed and very professional. Any issues are dealt with quickly and calmly".

Good

Is the service well-led?

Our findings

There was a friendly and welcoming atmosphere at the home. Staff worked collaboratively and spoke warmly about the people they supported. One visiting professional told us, "The fact that people can take their dogs gives it a really lovely feel". There were photos displayed in the home and a digital photo frame showing photos of people enjoying the home's events in reception. Part of the home's vision was, 'Always put quality first, providing our residents with first class care that we can be proud of'. Staff told us that they would be happy for their relatives to be cared for in the home if needed. One said, "I'd have no qualms about putting a family member of mine in here". A visiting friend told us, "They always make something special of birthdays. It's a lovely place here". Staff achievements were also celebrated, with one of the home's heads of unit being awarded the provider's senior nurse of the year award in 2014.

The culture of the home was open. Staff felt able to raise any concerns. One said, "I'm really happy here; if I did something wrong I know I would get the proper support to face it next time. They do try and fix it. You can build a bond with the residents and have a good time, it's a good community overall". Information on whistleblowing was displayed in the home and staff understood this. A CPN told us, "(The registered manager) is very open for us to come in. If there are any issues he will look into it". Where incidents had occurred these had been discussed openly with the person, their relatives and professionals such as the GP. Staff had received training in the new duty of candour regulation which is designed to ensure that providers are open and transparent. Posters around the home were used to remind staff of the principles underpinning this legislation. The registered manager said, "These posters were really for staff but they have resulted in useful conversation with relatives". On the day we visited a clinical meeting was scheduled. This meeting was to look at and learn from incidents.

People, their relatives and staff spoke highly of the registered manager and senior team. One staff member said, "It's a good place to work. The management is very good. (The registered manager) is helpful and approachable. He appreciates what you are doing. They are all available at any time". Another told us, "The manager is my role model and a very good man, you can call and ask the manager if you can see him and he will tell you when". The CPN said, "(The registered manager) is very fair. He can be firm but he is fair too". There was good communication in the home. The registered manager attended handover from the night shift and held a daily 'stand-up meeting' with the senior team. This meant that everyone was aware of changes in people's needs, of activities, training or professionals due to visit that day. This information was further cascaded by the heads of department. The registered manager was supported by the provider. They told us, "I feel confident and competent but if not I know exactly who to pick up the phone to".

The registered manager regularly assessed and monitored the quality of the service that people received. There was a 12-month audit plan in place which included, two full audits of the service each year and specific audits including of medicines and infection control. The full service audits included observation of the 'lived experience' whereby staff interaction, support and availability was monitored. The registered manager had also completed spot checks during the day and the night. Actions from audits were included in a 'central action plan'. This was a new initiative which the registered manager told us was working well. He said, "I used to have six action plans, I find this a really good tool". Actions had been completed, for example PRN medicine care plans were now in place and assisted bathrooms had been refurbished.

On a monthly basis, clinical information, including data on people's weights, pressure ulcers and accidents that had occurred was collated, analysed and sent to the provider. The provider used this information to monitor services and to target support. We noted that clinical staff from the provider had visited the home in March 2015 to review pressure areas, malnutrition and choking. Actions from this visit were included in the central action plan. The home had demonstrated improvements over the previous quarter, including a reduction in home acquired pressure ulcers, a reduction in falls and an increase in the number of keyworker entries in people's care notes. A representative of the provider visited the home on a monthly basis. This visit included a review of actions. There was an effective system to review the quality of the service, to set improvements and to monitor progress.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Where people lacked the capacity to consent the registered manager was unable to demonstrate that they had acted in accordance with the 2005 Act.** Regulation 11 (3)