Beaumont Nursing Home Limited

Downlands

Inspection report

96 The Drive
Hove
East Sussex
BN3 6GP

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11 April 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 11 April 2017 and was unannounced. Downlands Nursing Home provides nursing and personal care and support for up to 23 older people or people with a physical disability. The service offers long term and respite care. At the time of inspection there were 20 people living at the service. Accommodation is provided over three floors, in single rooms with en-suite facilities to all bedrooms. The service is located on a main road in a residential area, close to transport links to local shops, the seafront and the city centre.

The service had a registered manager. They were on maternity leave at the time of the inspection and the running of the home was managed by the deputy manager who was present throughout the inspection. 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.

At the last inspection in April 2016 we identified a breach of the Regulation in relation to a lack of person centred care. We also identified some areas of practice that needed to improve. The provider sent us an action plan in June 2016 stating that they had addressed these concerns. At this inspection we found that the provider had made improvements and people were being offered more choices and provided with a more person centred service. The provider had met the requirements of the Regulation but there remained some areas of practice that needed to improve.

Some risks to people were not effectively managed. Wound care was inconsistent and risks associated with the environment were not always identified and acted upon. This was found to be a breach of the Regulations.

Staff understood the principles of the Mental Capacity Act 2005 however, there was not a consistent and clear approach to determining whether people had capacity to make decisions about their care and undertaking best interest decisions where needed.

People's dignity was not consistently respected. A bathroom was being used as a storage area even though it was used by people. At meal times some staff were focused on the task and not on providing a positive experience for the person.

People and relatives knew how to raise complaints and concerns. However, some relatives felt that their concerns were not always listened to.

The provider had systems for monitoring quality in the service and we could see that improvements had been made. However some systems were not effective in identifying and driving improvements.

People told us they felt safe living at Downlands and there were sufficient staff to keep people safe. People received the medicines safely and staff knew how to recognise and report abuse. Staff knew people well and encouraged and supported them to express their views about their care and support. Relatives were able to visit at any time and told us that they felt welcome at the home. Staff had received training and people told us that they had confidence in the abilities of the staff. One person said "They are well trained and I think they all know how to care for me."

People spoke highly of the activities provided. Plans to develop a more person centred approach to providing meaningful occupation for people were in progress.
People spoke highly of the food and said that they were able to make choices about what they had to eat. People received enough to eat and drink and risks associated with nutrition were managed effectively. People were supported to access the health care services that they needed.

Staff morale was good and they had developed positive relationships with the people they were supporting. People told us they were happy living at the home.

We identified one breach of the regulations. You can see what actions we have asked the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Risks to people were not always effectively identified and managed.

Staff knew how to recognise and report abuse.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff understood the principles of MCA. However, there was not a consistent approach to determining whether people had capacity to make decisions about their care and undertaking best interest decisions where needed.

Staff received the support they needed to carry out their roles effectively.

People had enough to eat and drink and were supported to access health care services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring

People's dignity was not consistently respected.

Staff were kind and caring. Staff knew people well and supported them to express their views.

People's confidentiality and privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People were receiving person centred care however; care records were not always updated to reflect their current needs.

The activities programme was varied and developments to provide more personalised occupations for people were in progress.

There was a clear complaints process however not everyone felt that the service were responsive to issues that were raised.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Systems to monitor and improve standards were not always effective and improvements were not all sustained and embedded.

Staff morale was good and staff were clear about their roles and responsibilities.

There were robust links with the local community.

Downlands

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 11 April 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. On this occasion we did not ask for a Provider Information Return (PIR) before the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We contacted the local authority contracts team before the inspection. This enabled us to ensure we were addressing any potential areas of concern at the inspection.

We spoke to six people who use the service and five relatives. We interviewed seven members of staff and spoke with the acting manager and the area manager. We spoke with a visiting health care professional. We looked at a range of documents including policies and procedures, care records for eight people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's systems.

The last inspection of 5 April 2016 had identified one breach of the regulations and the overall rating for the service was Requires Improvement.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure living at Downlands Nursing Home. One person said, "I am never left too long, they respond quickly to the bell if I press it, so I do feel safe." Another person said, "I made the decision to come here and it was the right one, I feel a lot safer now. There's always someone around if you need help." A relative told us, "I am very happy with care and my relation is definitely safe here." Despite these positive comments we found some areas of practice that needed to improve.

People had risk assessments in place and care plans guided staff in how to provide care safely. However some risks to people's health and safety were not always identified and managed. For example, systems for managing wound care were not always effective. One person had a wound that required regular dressing. The Tissue Viability Nurse (TVN) had advised that the dressing should be changed every three days. Records showed that on five occasions the dressing was not changed after three days and on one occasion it appeared that the dressing had not been changed for more than ten days. Staff told us that they felt this was likely to be a recording error however they could not be sure whether the dressing had been changed within the ten day period or not. A second person also had a wound that required redressing every three days. Records showed that this had not happened consistently. One record within the staff communication book indicated that a dressing for this person had been changed on 25 February 2017, however this was not reflected in the wound assessment chart. Staff were not always sure that dressings were being changed in line with the recommendations to maximise healing and safe care of people's wounds.

Risks associated with the environment at the home were not always identified and managed. The bathroom on the lower floor was being used as a storage area for equipment such as hoists, staff uniforms, personal protective equipment (PPE) and cleaning materials. The room was cluttered and untidy and this posed a trip hazard for anyone using the bathroom. There was a wall mounted support rail around the toilet. It was unsteady to touch and was not secure. The rail was also very rusty which posed an infection control risk as it would be difficult to keep clean. Some people were being taken into this bathroom to use the toilet. We asked the acting manager how they could be assured that people were protected from health and safety risks when using this bathroom. They arranged for most of the stored items to be removed from the room immediately.

People had personal emergency evacuation plans (PEEPS) in place which identified the assistance that they would require in the event of needing to evacuate the building in an emergency, such as a fire. With the exception of one person, everyone's PEEP described them as needing the assistance of two staff and many people would be unable to mobilise without equipment such as a wheelchair. Some people had bedrooms on the first floor and although there was a lift, this would be unsafe to use in the event of a fire. The area manager and acting manager told us that in the event of a fire people would be supported to a safe area on the first floor until the fire service arrived to assist with the evacuation. The home had not assessed the risks to people at times when there were minimal staff on duty, such as at night. They did not have equipment such as evacuation chairs, in place that would enable staff to assist people downstairs in the event of an emergency. Since the inspection the provider has told us that they are in the process of purchasing equipment following recommendations made following an external fire risk assessment.

The inconsistent approach to identifying, minimising and managing risks is a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We checked whether safe recruitment procedures had been followed to ensure that staff were suitable to carry out their roles. The provider required prospective staff to complete an application form, provide two references and to have a criminal records check with the Disclosure and Barring Service (DBS), to establish if they were suitable. However we found that whilst some staff files contained appropriate paper work others did not. For example, not every staff file contained an application form with the staff member's employment history. Two application forms did have this information, but there were gaps in the dates that had not been accounted for. Some staff files did not have a DBS and one file had none of the required information. The acting manager told us that this was because some staff records were held centrally with the regional manager and others remained with another home. The registered manager could not be assured that recruitment procedures were operating effectively and that fit and proper persons were employed. This is an area of practice that needs to improve.

Staff told us that there were enough staff on duty. One staff member said, "I never have to rush," another said, "Staffing levels are fine, there is always a nurse on duty and we get time to spend with people." The provider used a dependency tool to assess the number of staff that were required to keep people safe. This showed that the number of staff on duty was adequate to care for people safely. Staff rotas indicated that the number of staff on duty was consistent and people told us that they felt there were enough staff. One person said, "Sometimes they are a little pushed for time but most of the time it's fine." We noted that staff responded to people's call bells swiftly throughout the inspection and people told us that this was usual.

People's medicines were administered, recorded and disposed of safely. Some people were receiving PRN (as required) medicines and there were clear protocols in place to guide staff about when these should be offered. We observed people having their medicines administered in a safe way and Medication Administration Records (MAR) were completed consistently.

Staff were able to describe how they would recognise if someone was being abused and knew how to report this. One staff member said, "I've had safeguarding training and I would report any concerns to the manager." Another staff member said, "If they (the manager) didn't do anything I would whistle blow to the local authority." Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. We noted that whilst the provider's safeguarding policy was currently being updated to reflect local arrangements there was a safeguarding flow chart in the office. This included the telephone numbers that staff or people would need if they wanted to raise a concern. Safeguarding records confirmed that appropriate actions had been taken when safeguarding concerns had arisen.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in April 2016 there were concerns that the provider had not always given due consideration to the principles of the Mental Capacity Act 2005 (MCA). This was because not all practices enabled people to make decisions about their own care and support. Some restrictions had been placed upon people without their consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we found that some improvements had been made however it remained that staff had an inconsistent approach to determining whether people had capacity to make decisions about their care and undertaking best interest decisions where needed.

Mental capacity assessments had been completed for some people where it was felt that they might lack capacity to make specific decisions. However we found that this practice was not consistent and there was contradictory information in some care records about people's ability to make specific decisions. For example, bed rails were in place for one person who was living with dementia. Bed rails can restrict people's freedom and therefore, when bed rails are used, consent should be sought or a best interest decision made in line with the legislation and guidance. A consent form covering use of bed rails had been signed by a staff member and stated that verbal consent had been gained from the person. There was no underpinning mental capacity assessment to confirm that the person had capacity to make this decision although they had been assessed as lacking capacity to make other decisions. Although there was a clear risk assessment and rationale for the use of the bed rails this did not include details of any best interest decision making process. This meant that a restriction had been placed on the person without their consent and without due consideration of the principles of the MCA. This was identified as an area that continues to need improvement to ensure that people's rights to make decisions are always being protected.

Staff had received training on MCA and DoLS and demonstrated a clear understanding of their responsibilities. One staff member told us "We have to consider the least restrictive option and people have the right to make unwise decisions." Another staff member said, "We have to give people a chance to make their own decisions." A third staff member said, "When people lack capacity a decision would need to be made in their best interest." Throughout the inspection we observed staff seeking consent from people before providing care. For example, we heard staff asking people, "Would you like your legs up?" "Where would you like me to put this?" and "Can I help you with that?" This showed that staff understood the importance of seeking people's consent. The registered manager had made appropriate DoLS applications for people and had followed any conditions attached to the authorisation.

Staff said they received an induction when they started work at the home which included shadowing an

experienced member of staff. Staff told us they felt confident in their role and that they received the support and guidance they needed. One staff member said, "The manager is very approachable." Another staff member said, "We have staff meetings once a month," and a third staff member told us, "I have had supervision and the manager is very supportive." Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Records provided mixed evidence of supervision. Some staff had not received supervision others were having irregular supervision meetings. The acting manager said that supervisions were undertaken on a three monthly basis however this was not verified in staff records. However staff told us that they felt well supported in their roles and that they had opportunities to raise matters of concern with their manager. Staff told us that they had opportunities to undertake training that was relevant for their roles. One staff member said, "I've done lots of training here." Another staff member said, "The care certificate was very good for me." The care certificate is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People told us that they felt staff had the skills and knowledge to carry out their roles effectively. One person said, "They are well trained and I think they all know how to care for me." Another person said, "I am never worried, they know what they are doing," and a third person said, "They are all good and their jobs." A visiting relative also spoke highly of the staff saying, "They have made a big difference to (person's name), we have seen a real improvement which is down to the skills of the staff here."

We observed staff practice throughout the inspection and found staff to be confident in their roles. For example two staff supported a person to move from a wheel chair to an arm chair with the use of a standing hoist. The staff took care to gain the person's consent before undertaking the manoeuvre and explained what they were about to do before starting the process. Throughout the transfer the staff members were calm, reassuring and confident, giving the person clear instructions and ensuring their comfort throughout. The person appeared relaxed and comfortable with the procedure, smiling at the staff and thanking them for their help.

Records confirmed that care staff had undertaken training and that they refreshed and updated their knowledge regularly. However there had been less opportunity for clinical training for nursing staff. For example, only the registered manager and the acting manager had completed wound care training. We found that systems for managing wound care were not always effective. The acting manager confirmed that they were in the process of booking training for the nurses and we identified this as an area of practice that needs improvement.

People told us that they had enough to eat and drink and they were happy with the food. The chef spoke to people on a daily basis about their meal choices and people told us they were always offered a choice between two main courses and desserts each day. We asked people what happened if they didn't like what was on offer. One person said, "If you don't want it you can choose something else. I sometimes have a sandwich or an omelette. It's nice home cooked food." Another person told us, "The food is good, but there's often too much, I can never eat it all." A third person said, "If you want anything different you just ask them and they will bring it." The chef was aware of people's individual preferences and needs and these were recorded in their care records. For example, the chef told us that one person was allergic to seafood, and we saw that this was reflected within their care plan.

Some people had been identified as having specific nutritional and hydration needs. Risk assessments had been undertaken and plans were in place to guide staff on how to support and manage people's needs. For

example, one person had been identified as being at risk of malnutrition following a period of unplanned weight loss. A referral had been made to the dietician and their advice to "continue with food as treatment" had been included in the care plan. This included ensuring that the person received additional calories provided in fortified milk shakes. Food and fluid charts were in place to enable staff to monitor the person's daily intake and these records consistently showed that milk shakes were being offered regularly as prescribed.

Some people were identified as being at risk of dehydration and fluid charts were used to monitor their fluid intake. These were consistently completed and totalled on a daily basis so staff could see if a person was receiving the fluids they required. We noted that staff were checking that people had a drink within their reach throughout the inspection and that staff were reminding people and supporting people to have regular sips of their drinks.

We observed the lunchtime experience for people. Some people were served their meals in the lounge area and others had their food in their rooms. Staff were supporting people who needed help to eat and people told us they enjoyed the food.

Some people had been identified as having swallowing difficulties and their care plans included guidance on the soft diets that were required. For example, one person had been referred to a Speech and Language Therapist (SALT) due to swallowing difficulties and their recommendation for thicken fluids and pureed food were included in the person's care plan. The chef was aware of who required a pureed diet and we observed people being served pureed food and thickened drinks.

People told us they were supported to access health care services and we noted many examples in people's care records that this was happening. One person said, "I wasn't too good and the staff decided to call the doctor." Another person told us, "If I need any appointments or anything the staff sort it out." A visiting relative told us that their relation had a forthcoming hospital appointment, they said, "I will tell them the details and they will make sure arrangements are made." Another relative said, "They are good at letting me know if they have to call the doctor or if anything changes." A third relative said, "I get regular emails to update me on how things are going and (person's name)'s health." We saw examples in people's records of visits to a range of health and care professionals including, opticians, chiropodists, SALT, dietician and social workers. A GP visited the home on the day of the inspection in response to concerns raised by staff about one person's health.

Requires Improvement

Is the service caring?

Our findings

People spoke highly of the kind and caring nature of the staff. One person said, "The staff are very kind, couldn't be nicer." Another person said, "I am very happy with the staff, they are all kind and very caring people." A third person said, "They have all been very kind, helping me to settle in, it was a big change for me and they couldn't do enough for me really." Relatives of people also spoke well of the staff and said that they felt welcomed in the home. One relative told us, "We can come at any time, staff are always friendly."

Despite these positive comments some aspects of care were not consistently caring because people's dignity was not always respected.

We observed how staff were supporting people with their lunchtime meal. Some people were in the lounge area. People were served their food where they were sitting and we did not see anyone being offered the opportunity to sit at the dining room table for their meal. Some staff offered people the choice of having an apron whilst other staff put aprons on without gaining people's consent. The television programme that people had been watching was switched off and music was put on without staff first seeking the opinion of people. There were no condiments or sauces offered for people to add to their meals and the lunchtime experience was task- led and functional instead of a pleasant social occasion.

Some people were being supported to have their food in their bedrooms. We noted that some meals were left on a trolley while staff served other people. Not all the food was covered, for example bowls of soup were not covered and were left to go cold for more than ten minutes, whilst staff served other meals. Some people needed support to eat and drink. One staff member stood over a person and not sitting beside them when assisting them to eat. There was little interaction between the staff member and the person. These observations showed that staff were focused on the task and not on providing a positive experience for the person. Some relatives told us that they did not feel that staff always respected people's dignity, an example given was of staff training that was provided in the lounge area even though people were using the space to watch television.

We have not judged these examples of poor practice to be a breach of regulations because people told us that they believed staff were respectful and they felt that their dignity was protected. We also saw a number of examples of good practice, including staff ensuring people's dignity was maintained when supporting them to transfer with the use of a hoist. However, we have identified that ensuring people's dignity is respected is an area of practice that needs to improve.

People told us that they had developed positive relationships with the staff. One person said, "I'm sure I get preferential treatment, they all like a chat with me." Another person said, "They have got to know me well and how I like things to be done. I know them pretty well too." A visiting relative said, "They know (person's name) really well and can anticipate their needs. I have nothing but praise for the staff here." People were involved in planning their care and told us that they felt listened to. One person said, "They go out of their way to make sure I am happy and have what I need." A relative told us, "They have been able to win my relation over because they listened to what she wanted, she is quite happy now."

Care records showed that people had been included in decision making where appropriate. For example, one person's care plan stated that the person had refused to have regular monitoring of their blood sugar levels and this decision was respected. A subsequent review note showed that the person had changed their mind and did now accept regularly checks on their blood sugar levels.

People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. We noted that some women were having their hair styled by a visiting hairdresser, others had their nails painted and wore make-up. One person told us, "I like a bit of lipstick and some make-up to brighten me up." Staff told us they understood how to protect people's privacy. One staff member explained that they always closed the curtains and put a sign on the bedroom door to ensure that other staff were aware that the person was receiving support with personal care. A staff member told us, "I always knock on the door and explain why I need to come in. I cover people up when they have a wash and ask them what they want to wear. Sometimes I help people choose based on the weather." Our observations throughout the inspection confirmed that staff were consistent in their approach to protecting people's privacy. Important personal information was kept in a secure cabinet and staff were discreet when discussing people's needs.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in April 2016 we found a breach of Regulation 9 of the Health and Social Care Act because the care and treatment of people had not always been provided to reflect their preferences. The provider sent us an action plan in June 2016 describing the changes they would make to address these concerns. At this inspection we found that there had been a number of improvements and the breach had been addressed. However we found other areas of practice that were not consistently responsive.

People were receiving care that was person centred and the previous breach had been addressed. People told us that they were offered more choices in their daily life including the type of food on the menu and what time they wanted to get up or go to bed. One staff member told us that the activities co-ordinator held residents meetings to consider what they would like on the menu and this information was passed to the chef. The chef also told us that people were able to make choices about the menu saying, "I talk to people every day about the menu and check what they like and don't like, that way I can make the dishes that they enjoy." People confirmed that these discussions were happening on a regular basis. People told us that they could choose what time they wanted to go to bed or get up. One person said, "I usually go to bed early but if there's something on TV I want to see I let the staff know and I stay up a bit later." Staff told us that they had been working with the Care Home In- Reach Team to gain a better understanding of person centred care. Notes from staff meetings confirmed that two workshops had taken place.

People's needs had been assessed and care plans reflected their needs and preferences. For example one person who was living with dementia had difficulties with understanding information. Their care plan guided staff to 'communicate using short clear sentences and to talk in a soft voice.' Another care plan addressed the needs of someone who was living with dementia and for whom English was not their first language. The care plan guided staff in how to communicate effectively by using some words from their own language. These words were displayed on the bedroom wall and included a clear description of their meaning as well as denoting how to pronounce the word. Staff told us that this was an effective way of supporting the person to communicate their needs and preferences. The person's care plan included information about their love of traditional music and we observed that this was quietly playing in the person's room.

Staff told us that the detail in care plans was useful in providing person centred care. One staff member said, "The care plans are informative and tell us what we need to know." Staff demonstrated a good knowledge of people's needs. One staff member said, "We use pictures to help one lady to communicate, she loves watching Jeremy Kyle and it makes her laugh and stops her from getting bored. We help another lady to eat, she can't speak much but she pushes her tongue out and we know that means she has had enough to eat." Care records did not always reflect people's life history but staff were still able to tell us about their background. For example, one staff member spoke about a person who used to drive a taxi and their love of cars, another told us about a person who had lived in the country and now enjoyed talking about "poppies and fields." Staff told us how they used such information to care for people in a person centred way. A staff member told us that one person sometimes became distressed; they said "We know that they love music and singing so we put some music on and sing along for a while to calm her."

Although there had been positive improvements with regard to person centred care, care plans were not always reflective of the current situation for people. People were at risk of receiving care that was not appropriate for their current needs. For example, one person had diabetes and their care plan indicated that blood sugar levels should be checked on a monthly basis. We could find no records of this having been completed. We asked why this was and staff told us that the GP had confirmed that there was no longer a need for these checks to take place however the care plan had not been updated to reflect this change.

Another person required insulin to be administered to control their diabetes. The details in the care plan stated the dose of insulin that was required in the morning and evening. This dosage had been changed and was different on the person's MAR chart. This meant that this person was at risk of receiving inappropriate care because records had not been updated to reflect changes. Ensuring that care records are updated and accurate is an area of practice that needs improvement.

A number of people were spending the day in their bedroom. One person who was living with dementia stayed in bed all day. Their care plan identified that they were at risk of social isolation and stated, "Likes to sit in the lounge," however staff told us that they preferred to stay in bed now. We noted that the activities co-ordinator spent some time with people who were staying in their rooms and they explained that they provided one to one support for people to reduce their social isolation. Some people spent the day in the lounge area, during the morning the activities co-ordinator spent some time talking with them about seeds that they had recently planted and showing them how much they had grown. After this people were left with little staff contact until just before lunchtime, and for at least an hour people had little to occupy them. Two visitors arrived during this period but we noted that staff were not spending time with people in the lounge.

People spoke highly of the activities programme and said that they enjoyed the organised events which included entertainers, a visiting choir and a petting dog. The activities programme was varied and the activities co-ordinator explained that people's ideas and interests were included in the programme as much as possible. We noted that a residents meeting had included discussions about forthcoming celebrations planned for Easter and the activities co-ordinator had spoken to each person about what activities might be interesting for them. Following the lunchtime meal an entertainer arrived to sing to people. Staff told us that not everyone would want to see the entertainer but there were not enough seats in the lounge area to accommodate everyone if people had decided to attend.

The activities co-ordinator told us that they had been working with the dementia in-reach team and the local activities co-ordinators' forum to develop their activities programme. They used information about people's life history to design meaningful activities that would be of interest to people. For example, one person said that they enjoyed gardening and they planned to encourage them to go into the garden and to be involved in growing plants that they would like. Another person liked pretty material and the activities co-ordinator was planning to make an individual rummage box to occupy them with a variety of different fabrics. These developments were not yet in place but were described as work in progress.

Staff told us that when the activities co-ordinator was not working they undertook one to one activities with people, including doing puzzles, watching films or reading the newspaper. The activities co-ordinator said that they were working with staff to develop their understanding of providing sensory moments for people by holding hands with someone or listening to music or having a hand massage. We saw an example of this in one person's care plan which described how the person loved perfume and guided staff to 'Apply perfume or talcum powder to promote their well-being and lift their mood.' The activities co-ordinator explained that they were gradually working with staff to provide more person centred activities that were meaningful to individuals. They described this as work in progress and said, "We are getting there, staff understand the importance of getting to know the residents so we can focus on them individually."

A complaints system was in place and the procedure was displayed on the wall near the main entrance for visitors and residents of the home to see. Complaints were logged and actions taken to resolve the issue. People told us they knew how to make a complaint, one person said, "I would speak to the staff if I was worried about something." Another person said, "I would ask to see the manager." Relatives expressed mixed views regarding how the service listened to complaints and concerns. Some relatives told us that they felt their views were welcomed and they felt comfortable to raise any concerns. However, other relatives told us that they had received a defensive response to issues that they had raised. Two relatives told us about complaints that they had raised where they felt staff considered them to be "moaning" and they said that this made them feel less inclined to raise any further concerns. One relative said that when they had raised issues in the past they did not feel that their concerns had been acted upon. We noted that the concerns people spoke of were not recorded in the complaints system and it was therefore not possible to confirm whether actions had been taken. Ensuring that people and relatives feel comfortable and confident in raising issues and complaints is an area of practice that needs to improve so that the provider can learn from people's experiences.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was on maternity leave at the time of the inspection. The acting manager was present throughout the inspection. People and staff spoke highly of the management of the home. One person said, "From what I can see it's a well-run home." Another person told us, "The current manager is very nice, very approachable and easy to talk to." A third person said, "I have no complaints about the management, it's very good." A relative told us, "The acting manager goes out of their way to help, they have been wonderful." Another relative said, "They keep us in touch with what's going on and I find they are very good."

Staff spoke with pride about working at Downlands Nursing Home, one staff member said, "I am happy because I work here, it's a big family here and I love working with the residents." Another staff member told us, "The care we give the residents is very good, I would recommend the home." Staff also spoke positively about management at the home. Their comments included, "We all get along well and work as a team," and "The manager is very approachable," and "The manager is very good and organised." Despite these positive comments we found that it remained that some areas of practice needed to improve.

Following the last inspection in April 2016 the provider sent us an action plan describing changes that had been made by June 2016. At this inspection we found that most areas of practice identified in the action plan had been completed and improvements had been made so that the previous breach of Regulations had been addressed. However some aspects of the action plan had not been completed and sustained. For example, recording of staff supervisions and appraisals were inconsistent. Despite improvements in training there remained inconsistent practice and understanding of MCA. Improvements in person centred care were evident however not all care plans were updated when people's needs changed. This showed that improvements had not been fully embedded and sustained to improve the quality of the service.

There were a range of systems and processes in place to enable the assessment and monitoring of the service and to drive service improvements. Not all the systems were effective. For example, care plan audits were in place however we found that care plans were not always up to date and accurate. An infection control audit was completed by the acting manager however this had not identified infection control hazards in the downstairs bathroom. A medication audit had identified the temperature in the medicine room was high. The homes policy stated that the temperature should not exceed 25°C however records showed the temperature was frequently 29°-31°C. No action had been taken to address this issue. Ensuring management systems are effective in driving improvements is an area of practice that needs to improve.

The provider used an annual questionnaire to gain people's views on the quality of the service. A report of responses showed that people were happy with the welcoming and friendly atmosphere at the home. All the responses were positive and the report noted actions that had been taken following the feedback. For example, new staff were introduced to a person who was visually impaired in order for them to be able to recognise new staff members. Other examples included improving telephone connections in the home to enable people to keep in contact more effectively. This showed that the provider was using feedback to improve the service.

Where management audits had taken place actions were recorded to address any identified issues. For example, it had been noted that some areas of the home needed to be redecorated and others needed a deep clean, an action plan showed when this work had been completed. The acting manager undertook monthly monitoring of incidents and accidents to identify trends and patterns. Actions were taken to try and mitigate any risks that were identified. For example, additional equipment had been introduced following evaluation of falls for one person.

The staff had made strong links with the local community including a number of health and social care professionals. Staff had attended training workshops with the Dementia Care Home In-Reach Team and one member of staff also attended the activity co-ordinator's forum where ideas and good practice were shared between providers. It was evident that access to these resources had helped staff to improve the provision of person centred care.

The acting manager worked on shift regularly as the registered nurse on duty. They told us that this enabled them to be aware of the day to day culture within the home and to monitor and support the staff. We found that staff morale was good and that staff were clear about what was expected of them. There were systems in place to support staff in the day to day running of the service, for example, a communication book identified important information that staff needed to know such as any planned appointments. One staff member said, "We have an allocation sheet each morning to tell us who we will be supporting that day."

The acting manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always identified, assessed and managed.