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Aspen House Care Home

Inspection report

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Hove
East Sussex
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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 19 July 2016 and was unannounced.

Aspen House provides accommodation for up to fifteen older people. On the day of our inspection there were twelve people living at the home. The home provides support for people living with varying stages of dementia along with healthcare needs such as diabetes and epilepsy. Accommodation was arranged over two floors with stairs and a stair lift connecting both levels. There was a communal lounge, a quiet lounge, dining room and gardens. The home is situated in Hove, East Sussex.

The home had a manager who was also the registered provider A registered provider is a '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.

We carried out an unannounced comprehensive inspection on 6 and 8 May 2015. Breaches of legal requirements were found and following the inspection the provider wrote to us to say what they would do in relation to the concerns found. At the inspection on 19 July 2016 we found that significant improvements had been made, however, we found a breach of legal requirements in relation to the failure to display performance assessment ratings. Further areas that needed improvement related to peoples' dining experience and the lack of choice in relation to food, as well as the lack of signage and adaptation of the building to assist people, who were living with dementia, to orientate around the building.

Part of the requirements of the provider's registration is to ensure that when their service is inspected by CQC, that they display their performance assessment rating to provide members of the public with an awareness of the rating of the service. The provider had not displayed the rating of the previous CQC inspection and therefore this was an area of concern.

People had sufficient quantities to eat and drink and were happy with the food. However, people told us that they didn't get enough choice in relation to the food that was provided. One person told us "There's a bit of choice at breakfast but you can't have a cooked breakfast or anything like that and at lunchtime it's a main meal in the dining room. You never know what it is unless it's Friday and you know it'll be fish then". People were able to choose where they ate their meals, most deciding to eat in the main dining area. Independence, with regard to eating and drinking, was not consistently promoted. Although people were observed to be independently eating their food, observations showed a member of staff moving from person to person mixing their food and putting spoonful's to people's mouths. People appeared not to welcome this support, which did not promote people's dignity or independence. This is an area of practice in need of improvement.

All of the people living in the home were living with dementia. Although the home provided a homely and relaxed atmosphere there were no adaptations or clear signage for people to orientate and know where their rooms, or other parts of the building were. Some people's rooms had been furnished with their

possessions and items that were important to them, whereas others were bare and stark and did not create a homely atmosphere. This is an area of practice in need of improvement.

People's safety was maintained as they were cared for by staff that had undertaken training in safeguarding adults at risk and who knew what to do if they had any concerns over people's safety. Risk assessments were personalised and ensured that risks were managed and people were able to maintain their independence. There were safe systems in place for the storage, administration and disposal of medicines. People told us that they received their medicines on time and records and our observations confirmed this.

Sufficient numbers of staff ensured that people's needs were met and that they received support promptly. People told us that they felt safe. When a visiting healthcare professional was asked about the staffing levels, they told us "Definitely enough staff, they chat with them, they're not left". Another healthcare professional told us "There are always lots of staff around and on hand". Staff were suitably qualified, skilled and experienced to ensure that they understood people's needs and conditions and plans were in place to provide training for newer members of staff. Essential training, as well as additional training to meet people's specific needs, had been undertaken or was planned. People told us that they felt comfortable with the support provided by staff. One person told us "I only have to ask and they help me or get it done".

People's consent was gained and staff respected people's right to make decisions and be involved in their care. Staff were aware of the legislative requirements in relation to gaining consent for people who lacked capacity and worked in accordance with this. People confirmed that they were asked for their consent before being supported and our observations confirmed this.

People's healthcare needs were met. People were able to have access to healthcare professionals and medicines when they were unwell and relevant referrals had been made to ensure people received appropriate support from external healthcare services. One person told us "I had the chiropodist just the other day so my toe nails are quite alright".

Positive relationships between people and staff had been developed. There was a friendly, caring and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People were complimentary about the caring nature of staff, one person told us "I find they are very kind to me".

People's privacy and dignity was respected and their right to confidentiality was maintained. People were involved in their care and decisions that related to this. Care plan reviews, as well as residents meetings, enabled people to make their thoughts and suggestions known. People's right to make a complaint was also acknowledged, however, people told us they were happy and had no complaints. One person told us "I don't worry about anything in here, no complaints". Another person told us "I can't complain about anything, but I would if necessary".

People received personalised and individualised care that was tailored to their needs and preferences. Person-centred care plans informed staff of people's preferences, needs and abilities and ensured that each person was treated as an individual. Staff had a good understanding of people's needs and preferences and supported people in accordance with these.

People, staff and healthcare professionals were complimentary about the leadership and management of the home and of the approachable nature of the management team. One member of staff told us "I love being here, it is a friendly, happy place, a lovely home". Another member of staff told us "I feel privileged to work here". There were quality assurance processes in place to ensure that the systems and processes

within the home were effective and ensured that people's needs were being met and people were receiving the quality of service they had a right to expect.

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 home was safe.

People received their medicines on time, these were dispensed by experienced staff that had their competence assessed. There were safe systems in place for the storing and disposal of medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks and maintain their independence.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People told us there was limited choice with regard to the food provided and people's dining experience was poor.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and had worked in accordance with this.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff and staff appeared to know people well.

People were involved in decisions that affected their lives and

their care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Good

The home was responsive.

Care was personalised and tailored to people's individual needs and preferences.

People had access to a range of activities to meet their individual needs and interests.

People and their relatives were made aware of their right to complain. The provider encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

The provider had not complied with a requirement of their registration with the CQC to inform people of the home's previous CQC rating.

People and staff were very positive about the management and culture of the home. Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals and their opinions and wishes were taken into consideration in relation to the running of the home.

Aspen House Care Home

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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 19 July 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home. On this occasion we did not ask the provider to complete 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. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

The home was last inspected in May 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation to the quality assurance processes and the staffing levels. The home received an overall rating of 'Requires Improvement'. After our inspection on 6 and 8 May 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

During this inspection we spoke with six people, four members of staff, two healthcare professionals and the provider. We reviewed a range of records about people's care and how the home was managed. These included the individual care records for four people, medicine administration records (MAR), six staff records, quality assurance audits, incident reports and records relating to the management of the home. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

Good

Is the service safe?

Our findings

At the previous inspection on 6 and 8 May 2015, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns regarding insufficient staffing levels that did not enable staff to spend one to one time with people. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to this regulation. Improvements had been made. The provider had introduced a dependency tool which assessed each person's care and support needs. These were monitored and used to inform the staffing levels. Observations demonstrated that staff took time to interact with people and they were provided with one to one time from staff. When healthcare professionals were asked about the staffing levels, they told us "Definitely enough staff, they chat with them, they're not left". Another healthcare professional told us "There are always lots of staff around and on-hand". The provider was meeting the legal requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the lack of personalised risk assessments was identified as an area that needed improvement. Following the previous inspection the provider had introduced personalised risk assessments. One person's risk assessment contained information in relation to the speed with which the person walked about their room and this had been identified as a risk. The provider had identified the possible risks and hazards, such as falls and banging into furniture and had taken measures to mitigate the risks, such as reminding the person to walk more slowly and moving objects that had the potential to cause harm. Another person, who was living with epilepsy, had a risk assessment in place that identified the triggers to the person's seizures, such as if the person had not had enough sleep or was hungry. Measures were in place to mitigate the risks such as medicine that could be given if the person was unable to sleep as well as ensuring that the person had access to snacks to ensure that they didn't get too hungry. Other measures, such as ensuring that staff were trained in first aid and removing objects in the person's room that could cause an injury were also in place. There were also clear guidelines advising staff of when they would need to call an ambulance if the person was to have a seizure. People's freedom was not restricted and they were able to take risks. For example, observations showed people independently walking around the home.

At the previous inspection the lack of mental capacity assessments in relation to the use of covert administration of medicines was identified as an area of practice in need of improvement. One person was supported to have their medicines covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example hidden in their food or drink. The provider had taken appropriate action. Discussions had taken place between the provider, GP and pharmacist to ensure that the person was provided with their medicines in their best interests and that these were administered in such a way so as not to alter the structure and effectiveness of the medicine. There was clear documentation in place to confirm this.

People were assisted to take their medicines by staff that had undertaken the necessary training and who had their competence assessed. Safe procedures were followed when medicines were being dispensed, the member of staff assisted one person at a time before moving onto the next person, to ensure that the risk or

errors were minimised. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person was supported by staff to take their medicine, which was a tablet, on a spoon. Staff assisted the person by placing the tablet onto the spoon and into the person's mouth. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

People were cared for by staff that the registered manager had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed, and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace.

Accidents and incidents that had occurred were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments had been updated to reflect changes in people's needs or support requirements. When people had fallen a 'Post fall incident report form' was completed, this analysed the factors that might have contributed to the fall such as the environment, trip hazards and the person's condition. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 6 and 8 May 2015, the lack of documentation to confirm the steps that had been taken to assess people's capacity was identified as an area of practice that needed improvement. Following the inspection the provider had taken the appropriate action. There was clear documentation in place to assess people's capacity when making specific decisions. For example, a mental capacity assessment had been undertaken for one person regarding the person's capacity with regards to taking their medicines.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People had DoLS authorisations in place, some of which contained certain conditions. One person's DoLS authorisation contained the condition that the person should be able to access the community. The provider had taken measures to ensure that this person, as well as others, had the opportunity to go outside for a walk or visit the local shops. People, healthcare professionals and staff told us that this took place and records confirmed that people had been offered the opportunity to access the community but had sometimes refused. Observations showed that consent was gained before staff supported people and people confirmed this. Staff showed a good understanding of MCA and DoLS and the implications of this for the people that they supported, they were booked to attend formal training for this, however, in the interim period the provider had ensured that they had the necessary knowledge and understanding to effectively support people, they had provided the staff with guidance and had asked staff to complete questionnaires. One member of staff told us "Every person has the right to do things on their own, but sometimes for their own safety they have to be escorted if they want to go out".

At the previous inspection on 6 and 8 May 2015, the lack of up-to-date documentation to confirm staff's training was identified as an area of practice that needed improvement. The provider had implemented a staff training matrix, this detailed what training the member of staff had received and when this needed to be updated. People told us that they felt that staff had appropriate and relevant skills to meet their needs. New staff were supported to learn about the provider's policies and procedures as well as people's needs and had started to work towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. In addition to this, staff that were new to working in the health and social care sector, were able to shadow existing staff to enable them to become familiar with the home and people's needs, as well as to have an awareness of the expectations of their role. Records showed

that most staff had undertaken essential training or were booked on a course to complete this. The provider had links with external organisations to provide additional learning and development for staff, such as the local authority and the dementia in-reach team. The dementia in-reach team provides advice, training and information for care homes that provide care to people living with dementia.

Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us "I have learnt so much, how to interact and how someone's mood can change. You have to be calm and know the person and sometimes give them more time and go back to them. I try to make them feel better". A majority of staff held diplomas in health and social care and staff told us that the provider had encouraged them to progress to the next level of diploma to aid their professional development. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. The provider did not conduct annual staff appraisals, they told us that it was a very small staff team and that learning and development needs were addressed within the frequent supervision meetings.

People told us that they were happy with the food. When asked if they had enjoyed the food at lunchtime one person told us "Oh very nice, especially the sauce, it was quite tasty". However, people told us that they didn't get much choice as to what they had to eat. One person told us "There's a bit of choice at breakfast but you can't have a cooked breakfast or anything like that and at lunchtime it's a main meal in the dining room. You never know what it is unless it's Friday and you know it'll be fish then". The availability of menus and mechanisms in place to enable people to choose and know what meal was available was discussed with the provider, they acknowledged that the introduction of a pictorial menu may assist people to better understand the choices available. Another person told us "No not much choice, set meals really". When asked about the choice people were provided with at mealtimes a member of staff told us "At breakfast there is a choice of white or brown bread and we have a set menu at lunchtime but if you see someone is not eating you can offer a sandwich. Lots of residents' here like their sandwiches". Following the inspection the provider told us that people were provided with choice and that there was one main meal, an alternative or sandwiches that were offered if people were unhappy with the main meal choice.

Most people went to the dining room for lunch, however, some people chose to have their meals in their rooms and this was respected by staff. There were dining tables that were laid with placemats, cutlery and plastic glasses. However, there were no condiments on the tables for people to season or flavour their food. Subsequent to the inspection the provider informed us that condiments had previously been removed from the tables as people were using these too much and spoiling their food, however staff should offer people the option of seasoning their food. Staff told us that there was one main meal and if people didn't like this then they could have an alternative or a sandwich. However, observations showed one person informing a member of staff that they didn't like their meal, the member of staff advised the person that the meal was nice but did not offer an alternative. Some people were provided with drinks of squash of their choice, whereas others were provided with a drink with no apparent choice provided. People were observed to be eating independently. However, observations showed one member of staff standing in the dining room observing people eat, and without interaction or explanation they went from table to table mixing up people's food on their plate and sometimes assisting people to put the spoon in their mouth, despite the people managing to eat without requiring assistance. Observations showed that one person looked unhappy about this and scowled at the member of staff and shook their head. This did not promote people's dignity or independence. The dining experience for people is an area of practice in need of improvement.

The Alzheimer's Society state that some people living with dementia may have difficulty moving around the home. That changes to the home can help people cope better with the difficulties they experience and maintain their independence. Observations showed that the environment had not been adapted to support people to orientate around the home. There were some signs informing people of where they could find the toilet facilities, however, there were no signs or names on people's doors assisting them to recognise their room. Some people's rooms were furnished with their possessions and items that were important to them, however, other people's rooms were very bare and stark. This was raised with the provider who explained that some people had minimal possessions, whereas others refused to have their possessions on display as they wanted to keep these in their own home. Although people may not have had many of their own possessions, their rooms were often very bare with no pictures or ornaments to decorate their rom and provide a homely feel. One person's room did not have a light shade on the light, just a bare light bulb. This did not create a homely environment and didn't enable people to easily recognise their rooms.

We recommend that the home considers the National Institute for Health and Social Care Excellence: Supporting people to live well with dementia guidance.

People's communication needs were assessed and met. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. Communication between staff was also effective. Regular handover and team meetings as well as daily written communication records, ensured that staff were provided with up to date information to enable them to carry out their roles.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists and district nurses. Healthcare professionals told us that the home responded promptly to people's health needs. One healthcare professional told us "One of the people I come here to see had a bad toothache, it's been a real challenge getting a dentist, the manager persevered and the person has seen a dentist and will be having treatment". Records showed that staff had responded promptly when there were concerns about people's healthcare. For example, one person had lost weight, staff had contacted the person's GP and had been advised to contact the dietician if the person's weight decreased further. Staff told us that they knew people well and were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. One member of staff told us "It might be because of an infection so I would tell the manager if the person wasn't acting like the person I knew". People told us that they had access to healthcare professionals when they needed them. One person told us "I had the chiropodist just the other day so my toe nails are quite alright".

Good

Is the service caring?

Our findings

There was a friendly and comfortable atmosphere in the home and people were cared for by staff that were kind and caring and who had a cheerful and approachable disposition. When asked, people and healthcare professionals praised the caring approach of staff. One person told us "They're nice here, all the people are nice". Another person told us "Yes there's nothing wrong with them, they're very nice". Whilst a third person told us "I only have to ask and they help me or get it done". One healthcare professional told us "From what I've seen definitely". Another healthcare professional told us "It's one of the best I've been to". Results of a survey sent to relatives to gain their feedback contained positive comments. One relative had commented 'The strength of the home is good as most of the residents seem happy'.

Observations of staff's interactions with people demonstrated their kindness and compassion. People were treated with respect and were cared for by staff that knew them and their needs well. Staff ensured that people were comfortable and showed genuine concern when people appeared to need their assistance. When a person was coughing, staff were overheard saying "Are you alright X"? Another member of staff was overheard saying "Aren't you hot in that cardigan X, would you like me to help you take it off"? One person preferred to spend the day in their room, observations showed that the person would sometimes communicate by shouting expletives. Staff demonstrated a patient and calm approach when assisting the person. One member of staff was overheard saying "How are you X? How can I help you? You're going to have your lunch soon". This appeared to calm the person and they were overheard telling the member of staff how kind they were and how much they liked them. People confirmed the caring nature of staff, one person told us "I find they are very kind to me".

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, wearing clothes of their choice. Diversity was respected with regard to people's religion and this was documented in people's care plans and hymns were included as part of the activities programme.

People were involved in their care. Records showed that people had been asked their preferences and wishes when they first moved into the home and that resident meetings had taken place. People were able to reminisce about their past and enjoy conversations with each other or discuss activities that they would like to do. Records of a recent residents meeting showed people had discussed and agreed on the type of television programmes they would like to watch.

Observations confirmed that people were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect and that they took time to talk, explain information and listen to their needs. The provider had recognised that people might need additional support to be involved in their care, they had involved people's relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Some people had a paid representative to ensure that their rights were being

promoted and they were being supported according to their DoLS authorisations.

People's privacy was respected. Information held about people was kept confidential, records were stored in offices to ensure confidentiality was maintained. Staff showed a good understanding of the importance of privacy and dignity and how this should be maintained. People confirmed that they felt that staff respected their privacy and dignity. Observations of staff interacting with people showed that people were treated with dignity and respect. For example, when assisting people to access the toilet facilities, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. One member of staff told us "Even when people are confused you still need to respect their right to make decisions for themselves and maintain their privacy and dignity. I always knock on people's doors and ask them if it is okay if I help them, if it isn't, I respect that and go back a bit later when they are ready". Healthcare professionals confirmed that staff respected people's privacy and dignity. One healthcare professional told us "They always make sure I have a private room to see people in". Another healthcare professional told us "It's no problem at all, we use a quiet room or go to people's own rooms. If staff need to assist people they do so and I leave the room".

Independence was encouraged and staff recognised the importance of enabling people to be independent. Observations showed people walking independently around the home, choosing where they spent their time and what activities or pass times they took part in. Staff told us that people were encouraged to be independent. One member of staff told us "X, for example, gets up early and dresses independently so does it all alone when X wants".

Good

Is the service responsive?

Our findings

At the previous inspection on 6 and 8 May 2015, a recommendation was made regarding improving the provision of activities and stimulation for people. At this inspection we found that improvements had been made in this area.

The Alzheimer's Society state that spending time participating in meaningful activities can continue to be enjoyable and stimulating for people and taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Care plan records for one person stated that the person used to be an art teacher, staff also told us about this and we were able to see the person enjoying taking part in an art and craft session. Another person's care plan stated that the person enjoyed listening to music by Elvis Presley and observations showed the person, as well as other people, listening to this type of music and enjoying singing along with staff. Further observations showed some people enjoying a game of skittles. Staff took time to interact with people and were observed sitting alongside people chatting. On the day of the inspection the weather was very hot and a member of staff was overheard saying "Would you like to go out into the garden for a cup of tea, I can put the umbrella up for us"?

Records showed people were supported to take part in a range of activities, these included: PAT dogs (Pets as Therapy), exercises to music, arts and crafts, discussions, make-up sessions, reminiscence, musical entertainment, film clubs and an afternoon tea dance. An external activities coordinator visited the home three times per week to offer a variety of activities. On the day of inspection people took part in an arts and crafts activity. People appeared to really enjoy this, they were observed smiling and laughing and clearly enjoying the interaction with the activities coordinator, who clearly had a good rapport with people. Healthcare professionals confirmed that people were supported to take part in activities and that they had observed this when they visited the home. One healthcare professional told us "I've seen them listening to 1940's music, playing ball games and having sing songs. People also go into the garden when the weather is nice". One person confirmed this, they told us "I sat out there last week I think, it was very pleasant too".

Staff were mindful of people who chose not to go to the communal lounge and ensured that they were not isolated in their rooms. People were informed about the activities available and encouraged to participate, however people's right to choose how they spent their time was respected. Observations showed people who had declined to take part in activities, choosing to spend their time in their rooms or in quieter spaces within the home. Following the previous inspection the provider had introduced a timetable which ensured that two people each day were offered the opportunity to go out into the community for a walk or to the local shops. The provider and staff told us that this was flexible and if people chose not to go out this was respected and other people were supported in their place. Records showed that people had been provided with opportunities to go into the community. One person told us "They took me in a taxi to one of these small shops just in and out and back". Staff showed a good understating and knowledge of the people they supported. One member of staff told us "X used to be a footballer and they talk about it with you when you sit and chat to them". Another member of staff told us "It's important we give residents the time to talk to us. X was an art teacher and enjoys the craft activities".

At the previous inspection there were concerns in relation to call bells not working and people being unable to summon for assistance if needed. Improvements had been made and the provider had introduced a system where staff checked the call bells in each room, each day. Other measures to ensure people's safety were also in place. Risk assessments had also been completed to determine people's ability to use the call bell if they needed to summon assistance. Some people had been assessed as being able to use the call bell, others, who due to their capacity, had been assessed as not being able to use the call bells. Due to the care needs of people living at the home, staff members carried out hourly checks of people to ensure their wellbeing.

People's social, physical and health needs were met. It was evident that people had been asked their wishes and preferences and their needs had been assessed, when they first moved into the home. Care plans were devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. In addition to information about people's care and support needs, staff had been provided with information about people's life histories and background to enable them to have a better understanding of the person's life before they moved into the home. Care plans had been reviewed in response to people's feedback or changes in their needs. When asked how people and their relatives were involved in the review of care plans, the provider told us that people are asked about their wishes and that relatives are invited to come to reviews, but would also be asked their opinions when visiting their relatives.

Apart from the concerns in relation to people's choice of food, people were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what time they wanted to get up, what clothes they wanted to wear, what activities they wanted to do and what they needed support with.

There was a complaints policy in place. There had been one complaint since the last inspection, this had been dealt with appropriately and in accordance with the provider's policy. The provider encouraged feedback from people and their relatives. There was a suggestion box for people and relatives to use and people and relatives had been asked to complete surveys to gain their feedback on the service provided. People were happy with the service they received. One person told us "I can't complain about anything but I would if necessary". Another person told us "I don't worry about anything in here, no complaints".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 6 and 8 May 2015 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not robust mechanisms or systems in place to assess, monitor or mitigate risks and to drive improvement in relation to the audit processes that were in place. At this inspection we found that improvements had been made. At the previous inspection there were concerns regarding the lack of oversight of the amount of falls that had occurred within the home and the lack of action take to mitigate the risks. The provider had introduced a falls assessment and audit to enable them to monitor and evaluate falls to determine any patterns or trends. In addition to this the provider had introduced more comprehensive audit processes to clearly show who had undertaken the audit, what was found and what improvements the provider planned to make. The provider was meeting the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However we found an area of practice that required improvement.

The manager was not fully 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. However, part of the provider's registration requirements relates to the displaying of a CQC performance assessment. Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated service and on their website if they have one. The home had been inspected in May 2015, however, the provider had not displayed the rating of the home. This was raised with the provider who informed us that they were unaware of this requirement. Following our inspection the provider wrote to us to inform us that their rating was now displayed. Not displaying a rating was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a manager who was also the registered provider. The management team consisted of the provider/manager and a deputy manager. When asked about the ethos of the home, the provider told us "We aim to make sure we can provide them with the best possible care, that they are comfortable, content and happy". This was demonstrated in the practice of staff, who appeared happy in their work and compassionate in their approach. One member of staff told us "I love being here, it is a friendly, happy place, a lovely home". Another member of staff told us "I feel privileged to work here". Healthcare professionals also confirmed that the ethos of the home was embedded in practice. One healthcare professional told us "It's fantastic, wonderful, it's a nice size and has a good atmosphere". People, staff and healthcare professionals were complimentary about the leadership and management of the home. They told us that the provider was friendly and approachable and listened to and acted upon their comments and suggestions. One member of staff told us "The manager and the deputy do good work, they are perfect". A healthcare professional told us "The manager is very proactive". Another healthcare professional told us "It's very good, if I had a place like this I'd want someone like them to run it, they are both calm and it is run really well".

There were quality assurance processes in place such as surveys that were sent to gain feedback from people and relatives. These enabled the provider to monitor people's satisfaction with the service received.

Results from the recent survey found that people and relatives were happy with the quality of care people received. Regular meetings enabled the provider to share information with the staff team and people living in the home. Staff told us that they were able to share their ideas and suggestions and that these were welcomed and listened to. Records of a recent staff meeting showed that topics such as the updated falls policy, infection control and activities had been discussed.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority and the dementia in-reach team. The manager worked closely with external health care professionals such as the GP and district nurses as well as attending manager forums to ensure that people's needs were met and that the staff team were following best practice guidance.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered person had not displayed a rating of its performance following an assessment of its performance by the commission.