Elderly Care Home Limited

Avalon Nursing Home

Inspection report

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

At our previous inspection of Avalon Nursing Home on the 3, 4 and 12 August 2015 we found breaches in regulation. We found there were not enough staff deployed to meet people's needs. Staff had not received appropriate support or supervision. Staff did not understand their individual responsibilities in reporting safeguarding concerns. Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. The registered person had failed to notify the Care Quality Commission about any incidents that affected people who used the service. A notification is information about important events which the provider is required to tell us about by law.

We also found breaches in regulation where care and treatment had not been provided in a safe way. The premises were not always hygienic or safe to use. Care was task based rather than responsive to individual needs. People were not consistently treated with dignity and respect. The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. We issued warning notices for these breaches. A warning notice includes a timescale by when improvements must be achieved. If a registered person has not made the necessary improvements within the timescale, we will consider further enforcement action. The provider sent us an action plan and told us they would address these issues by February 2016.

We undertook an inspection on 9 and 12 May 2016 to follow up on whether the required actions had been taken to address the previous breaches identified. We found significant improvements had been made. However, these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

Avalon Nursing Home provides nursing and personal care for up to 38 older people, some of whom are living with a dementia type illness. There were 28 people living at the home at the time of the inspection. In addition to living with dementia people had a range of complex health care
needs which included stroke, diabetes and Parkinson's disease. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

At the time of the inspection there was no registered manager at the home. There was a manager in post who had submitted an application to register with the Care Quality Commission (CQC) and were registered shortly after 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.

There was a system in place to assess the quality of the service provided. The provider and manager were aware of the shortfalls we identified and were working to ensure improvements were made and embedded into everyday practice.

People were supported by staff who knew them well, were kind and caring and enjoyed looking after people. There was an emphasis on providing good person-centred care and getting to know and understand people as individuals. However, care plans did not always provide staff with the information they required to support people and did not always reflect the care people received. We observed staff had built a good rapport with people and responded to staff with smiles and affection.
There were a range of environmental and individual risk assessments in place to ensure people were looked after safely. However, information from risk assessments was not always used to update people's care plans.

Mealtimes were an enjoyable and social occasion where people received the appropriate care and support they required.

Staff understood the principles of consent and the Mental Capacity Act (2005). Mental capacity assessments were in place and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. However, best interest decision were not in place for everybody who needed them.

Staff had a good understanding of safeguarding; they were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

There were enough staff working each day to ensure people's needs were met in an unhurried way. There was a robust recruitment procedure so only staff suitable to work at the home were employed.

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

Avalon Nursing Home was safe and the provider was meeting the legal requirements that were previously in breach.

Staff had a good understanding of the risks associated with supporting people who lived at the home.

The management and storage of medicines was safe, and people received their medicines as prescribed.

There were enough staff on duty who had been appropriately recruited to safely meet people's needs.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

The home was clean and tidy throughout and well maintained.

Is the service effective?

Requires Improvement

Avalon Nursing Home was effective and the provider was meeting the legal requirements that were previously in breach. Although staff with understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. However, best interest decisions were not always in place for people who shared bedrooms.

Although staff with understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been submitted when required.

Mealtimes were promoted by staff as providing a "good dining experience" for everybody. People's nutritional needs were met and people could choose what to eat and drink on a daily basis. The meal times were enjoyed by people and were a sociable occasion supported by staff in an appropriate way.

Staff received on-going training and supervision to ensure they could meet the individual needs of people living at the home.

Avalon Nursing Home had been adapted to promote the independence and better suit the needs of people living with dementia.

People were supported to have access to see their GP or other healthcare professional when they needed to.

Is the service caring?

Good

Avalon Nursing Home was caring.

Staff knew people well and had good relationships with them.

Staff spoke with people in a very caring, respectful and compassionate manner.

People were treated with respect and the staff understood how to provide care in a dignified manner.

Is the service responsive?

Requires Improvement

Avalon Nursing Home provided responsive care and was meeting the legal requirements that were previously in breach. However, these improvements need time to be fully embedded into everyday care delivery.

Care plans needed to be improved to ensure they all contained the information staff needed to meet people's individual needs.

Staff had a good understanding of providing person-centred care and there was an emphasis on getting to know and understand people as individuals.

Activities were meaningful and specific to each person's needs and choices. People had the opportunity for social interaction with staff on a regular basis throughout each day.

The service sought feedback from people and their representatives about the overall quality of the service.

Is the service well-led?

Requires Improvement

Avalon Nursing Home was well-led and was meeting the legal requirements that were previously in breach. However, these improvements need time to be fully embedded into everyday care delivery.

Care plans did not include all the information about the care people needed or received. The provider and manager were

aware of this and working to ensure improvements were made. There was an effective system in place to assess the quality of the service provided.

There was an open and positive culture at the home. This was focussed on ensuring people received good person-centred care.

The staff told us they felt supported and listened to by the manager.

Avalon Nursing 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 service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection on 9 and 12 May 2016. It was undertaken by three inspectors 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 service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the action plan sent to us by the provider. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records five staff files including staff recruitment, training and supervision records, medicine records complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with seven people who lived at the home, eight relatives, and fifteen staff members. We also spoke with the provider who was present throughout the inspection.

We met with people who lived at Avalon; we observed the care which was delivered in communal areas to

get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At our inspection on 3, 4 and 12 August 2015 we found the provider had not met the regulations in relation to: the safe care and treatment of people; the premises were not always hygienic or safe to use; there were not enough staff deployed to meet people's needs and staff did not understand their individual responsibilities in reporting safeguarding concerns.

Due to the concerns found at the last inspection, we determined people were at significant risk of not receiving safe care and the delivery of care was inadequate. The provider sent us an action plan and told us they would address these issues by February 2016. At this inspection we found significant improvements had been made and the provider is now meeting the requirements of Regulations 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able told us they felt safe living at the home. One visitor told us their relative was, "Very safe and secure here." Another visitor said, "Staff keep a watchful eye so that those who were able can walk round the building, like they would in their own home." Visitors told us people received their medicines when they needed them. One said, "Medication is always on time and distributed by brilliant nurses." Another told us, "My relative has improved considerably since moving to Avalon because they (staff) sorted out the medication."

There were a range of environmental and individual risk assessments in place for example in relation to people's mobility, risk of falls and nutrition. Staff we spoke with had a good understanding of the risks associated with supporting people. However, care plans associated to the risk assessments did not always include the current information about how to provide care. Risk assessments were in place for people who were prone to falls, these included information about the risk and what actions had been taken. For example one person had been referred to the falls team and a 'falls mat' was in place when the person was in their bedroom.

Risk assessments had identified people were at risk of pressure area damage. There was information in care plans about the support people required to maintain their pressure areas. This included information about pressure relieving equipment such as air mattresses or cushions. We saw these were set appropriately and checked twice a day by the nurses. Nurses told us it was their responsibility to check people's weights weekly and ensure the correct setting was recorded and set. Care plans informed staff when people required their positions to be changed regularly. Through our observations and records we saw people's positions were regularly changed.

Incident and accident forms had been completed when required. These included information about what had happened, the action taken and measures in place to prevent a reoccurrence. Where appropriate these were cross-referenced with safeguarding referrals which enabled the manager to identify further actions that were needed. There was evidence of learning from previous incidents, for example if a person sustained a head injury they would always been taken to hospital for assessment by appropriately trained professionals. Where people had specific health problems for example catheter care, diabetes and support for people who

were prone to seizures there was guidance in their care plans for staff to follow to ensure people received the care they required. We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member said, "We don't restrict people unless we absolutely have to and it's done with people's families"." Another staff member told us, "We do have a keypad system on the doors to prevent accidents and people going missing but we try not to restrict people"." The staff we spoke with understood people's rights to take risks, except in circumstances where the risks were not fully understood. Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs and the assistance required in event of an emergency evacuation.

Staff received regular safeguarding training and updates. Following previous concerns there had been a safeguarding plan by the local authority in place. The provider had worked with the local safeguarding team to address issues and ensure people were protected. Staff we spoke with were able to identify different types of abuse and the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would speak to a colleague if they weren't treating someone well, but I'd still report them to the manager". Another staff member said, "I would report anything bad to the manager and if they did nothing I would go to Safeguarding." Care staff were confident the manager or nurses would act on any concerns they raised. They told us the manager operated an 'open door' policy and that they were able to share any concerns they may have in confidence. The manager was aware of her responsibilities in reporting any concerns that may be considered safeguarding. Where concerns had been identified these had been referred appropriately to the safeguarding team for review.

At this inspection we found that there were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. In addition to the care staff and nurses the manager and area manager who were also nurses worked at the home five days a week. There was also a housekeeping team, a chef and two kitchen assistants. There was an activities co-ordinator and activities staff in place. We asked staff about staffing levels at the home. One staff member said, "Yes, we have plenty. I always have time to sit and speak with people." Another staff member told us, "The manager always makes sure there are plenty of staff. If a shift isn't covered then agency staff are brought in." A third staff member said, "I think there are enough staff to keep people safe but not to spend time with people." However, throughout the inspection we observed staff spending time with people, sitting and chatting and attending to them in an unhurried and timely way." A visitor told us, "Staffing levels have greatly improved. "It feels a bit quieter at the weekend but no problems."

People were protected, as far as possible, by a safe recruitment system. Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work at the home. There were copies of other relevant documentation including references, interview notes and Nursing and Midwifery Council (NMC) registration documentation in staff files.

Medicines were managed safely. Medicine administration of medicines followed guidance from the Royal Pharmaceutical Society. Medicines trollies were locked when left unattended. Staff did not sign Medicines Administration Records (MAR) charts until medicines had been taken by the person. We saw they were fully completed to show when medicines had been given or why they had been omitted. MAR charts contained relevant information about the administration of certain drugs, for example in the management of medicines to prevent blood clotting such as warfarin. In addition, each person taking 'as required' (PRN) medicines, such as pain killers had an individual protocol. This described the reason for the medicines use,

the maximum dose, minimum time between doses and possible side effects. Medicines were ordered, stored and disposed of safely. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the individual. Other medications were safely stored in locked cabinets in a locked room. No-one at the home self-medicated, that is managed their medicines independently. Some people had their prescribed medicines in tablet form, which were crushed before administering. We saw that on each occasion this process had been approved in writing by the person's GP. The nurses were knowledgeable about the medicines people received they told us they received regular training and records confirmed this. Nurses underwent a process of regularly checking their competency to administer medicines. There were regular audits of medicines which included the MAR charts, ordering, dispensing and disposal of medicines to ensure safe practice was maintained.

The home was clean and tidy throughout. We identified one bedroom where there was an unpleasant odour the provider and manager assured us this would be addressed immediately. Where required each person who used a hoist had their own sling to prevent the risk of cross infection. Doors labelled to 'keep locked' were locked. Cleaning products were stored safely and out of the reach of people to avoid harm. Extra storage areas had been built which reduced the amount of clutter identified at the last inspection. There was on-going maintenance to the home with redecoration taking place on the ground floor. The provider told us first floor redecoration was planned for the near future.

Requires Improvement

Is the service effective?

Our findings

At the inspection on 3, 4 and 12 August 2015 we found the provider had not met the regulations. This was because mealtimes were not an enjoyable experience; where people did not have the capacity to consent the registered person had not acted in accordance with legal requirements and staff had not received appropriate support or supervision.

The provider sent us an action plan and told us they would address these issues by February 2016. At this inspection we found significant improvements had been made and the provider is now meeting the requirements of Regulations 9, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

People told us food was good and they had plenty of choice. One person told us, "The food is excellent and very substantial the choice is very good." Another said, "They will let you have something different if you don't like the choices that they are serving." A visitor said, "The food is good, I've had a number of meals here. If I was in a hotel I'd be very satisfied." We were told staff understood people's needs. One visitor said, "The Staff are really brilliant, they really care."
Another said "I don't know whether they are well trained or not but I don't see many faults." People and visitors confirmed they were able to see their GP whenever they wished.

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 service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications, for people who did not have capacity and were under constant supervision by staff, had been submitted. There were mental capacity assessments in care plans. These informed staff that people were not always able to make choices. However, they did not include detailed guidance about how staff could support people to make decisions or how their consent was sought. Where people were restricted there was no guidance about how restrictions could be minimised.

Best interest decisions had been made for some people. For example some people received medicines covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. We looked at documentation related to this. Mental capacity assessments had been undertaken and 'best interests' decisions made, with all relevant people and agencies involved in the process. This was consistent with the law and the provider's policy. A person shared a room with another person, had a best interest decision

made about whether Avalon nursing home was the best place for them to live. Although there was no evidence of a discussion about the shared room the provider told us all those involved in the decision making process were aware of this. However, best interest decisions were not in place for everybody who shared a bedroom. We raised these with the provider as areas that need to be improved.

Best interest decisions had been made for some people. For example some people received medicines covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. We looked at documentation related to this. Mental capacity assessments had been undertaken and 'best interests' decisions made, with all relevant people and agencies involved in the process. This was consistent with the law and the provider's policy. A person shared a room with another person, had a best interest decision made about whether Avalon Nursing Home was the best place for them to live. Although there was no evidence of a discussion about the shared room the provider told us all those involved in the decision making process were aware of this.

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA) (2005). Staff had undertaken recent training in this area and had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They could tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. We observed staff asking people's consent prior to offering care and support throughout the inspection.

Staff received appropriate training and support to enable them to meet people's needs. Staff who were new to care undertook the Skills for Care Certificate training. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "It was fine, I wasn't new to caring before I came here but I got time to shadow staff and get to know the residents." Another staff member said, "The induction was great. I hadn't been a carer before. I shadowed a lot and felt safe the entire time."

Staff received regular training and updates. One staff member said, "I've done a lot of training since I've been here." Another staff member told us, "Training is great here. Most of it is face to face which I prefer." Training records and staff files showed staff were able to access training in a wide variety of subjects relevant to the care needs of the people they were supporting. This included falls prevention, wound care, continence awareness and epilepsy awareness. Staff were currently receiving support and training from the East Sussex Dementia In Reach Team. This training supported staff to understand person-centred care specific to people living with a dementia type illness. Staff were also able to undertake further training for example the diploma in health and social care.

There was a supervision programme in place and this was currently undertaken by the provider and the manager. As part of supervision the provider discussed with staff their knowledge and understanding, their opinions of the care provided and any areas they thought needed to be improved. For example some staff had identified activities needed to be improved for people therefore a meeting was held to discuss changes to activities for all staff which enabled them understand the changes. The provider also undertook observations of staff in practice. This included feeding back to staff observations of their interactions with people. For example how staff spoke to people or whether they responded to people when they required support. Informal supervisions and updates took place regularly throughout the day. There was a daily handover where staff were updated and asked about areas of practice for example safeguarding and mental capacity. Some staff told us they had not received formal supervision for some time. One staff member said,

"I can't say I've had supervision since but I don't feel unsupported. I can speak to my manager at any time." Another staff member told us, "I think the manager has been really busy since they started sorting other things out. It's not a problem for me though. I know I can see them anytime I want." Staff files contained supervision agreements with a view to future provision.

At our previous inspection the mealtime experience was not pleasurable for people. At this inspection we saw changes had been introduced and significant improvements made. Staff told us the emphasis was on providing a "good dining experience" for everybody which involved all staff. Mealtimes were protected. This meant people's meals were not interrupted unless essential and medicines were given after lunch. There were dining areas and individual tables in each lounge and people were supported to choose where to eat. Tables were well presented with tablecloths, table mats and condiments. People who required support were assisted in a dignified manner with care staff interacting and supporting them. They also gave them the opportunity to eat at their own pace. In addition to soft drinks people were offered a choice or wine, sherry or beer with their meal. Where people declined their meal alternatives were offered. We saw one person had requested some cheese and this was provided. Another person was very sleepy and declined their food. We saw staff return to the person with food sometime later and they ate a good meal. There were menus on display and the manager told us they were in the process of developing a pictorial menu to support people making choices.

There was a choice of meals available to everybody. The provider had recently introduced cooked breakfasts for people who wished to eat them. The chef had a good understanding of people's dietary needs and preferences. There was information displayed in the kitchen which informed staff who was at risk, the type of diet and what support they required at mealtimes. This included prompting, pureed diets, or fortified food. People who had lost weight of were at risk of malnutrition were provided with fortified milk shakes which were high in calories and easy for people to drink and helped to prevent weight loss. People were provided with regular drinks and snacks throughout the day, this included a choice of cake each afternoon.

There were nutritional assessments in place and some people were identified at risk of malnutrition or dehydration and contained information for staff, for example to provide fortified drinks or finger foods. Where appropriate people had been referred to the dietician or speech and language therapist (SALT). Staff told us some people were at risk of choking therefore they received pureed meals and thickened fluids. We saw guidance from the SALT in care plans to guide staff.

There had been changes in the design and adaptation of the home to promote the independence and better suit the needs of people living with dementia. The communal corridors on the ground floor had been decorated in bright colours. The corridors were themed for example one corridor had sports memorabilia another had black and white photos of film stars. This prompted people to identify where they were in the home. Staff told us people also stopped to look at the pictures and chat about them. People's bedroom doors had photos or pictures of something that was identifiable or important to the individual and there was signage to show people where bathrooms and toilets were. The provider and manager told us about further adaptations they were planning to make to develop the outside space and first floor. The seating areas in the lounges had been re-arranged. Chairs were now positioned in small groups rather than around the room. This supported people to interact with each other. There were woollen blankets and cushions on the chairs. These gave a homely feel and staff explained how different textures were important in providing people living with dementia, with sensory stimulation.

People were able to see a doctor if needed and that staff would arrange this for them. One person said, "They will send for a G.P if you have a cold or flu." Another said, "I had the same G.P I had at home." A visitor told us they asked if their relative could have a flu jab and was told, it had already been done. Care records

showed external healthcare professionals were involved in supporting people to maintain their health. This included GP's, tissue viability nurses, dietician, speech and language therapist and the falls team for people who were at risk of falls. Visitors told us if there was any change in their relative's health the appropriate healthcare professionals were contacted.

Good

Is the service caring?

Our findings

We carried out an inspection on 3, 4 and 12 August 2015 we found the provider had not met the regulations. This was because people were not always treated with the respect they deserved and their dignity was not always maintained.

The provider sent us an action plan and told us they would address these issues by February 2016. At this inspection we found significant improvements had been made and the provider is now meeting the requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors we spoke with told us staff were caring and kind. One person said, "They treat me with dignity and respect" Another person told us, "Wonderful, they're all great." A visitor told us "Staff are caring and respectful at all times, they let people do as much as they are capable of doing but they step in when necessary." Another visitor said, "My relative now looks upon this place as home, staff they understand my relative very well." Staff told us "I look after people how I'd want my parents looked after."

Since our last inspection improvements had been made to the culture of the service and we found staff to be caring and focused on providing a personalised service rather than just completing care tasks. People were looked after in an environment that was clean and tidy which was being adapted to meet their needs.

We observed care in communal areas throughout the day. People had positive experiences which were created by staff who understood their personalities, took time to chat with them and provide assurance. Staff took as much time as was needed throughout the day, to provide reassurance to people who were anxious or confused. Staff were comfortable in displaying warmth and affection toward people whilst respecting people's personal space. There was a high level of engagement between people and staff and we saw lots of genuine displays of affection throughout the inspection. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. We observed one person sitting on a sofa with a member of staff. The person had rested their head on the staff members shoulder. They sat until the person wished to move. Later we observed the person hugging another staff member. Staff told us displays of affection were important for this person. Another staff member told us, "I have just helped another person to bed for a rest, she gave me a lovely hug, I wish you could have seen it, it helps me know she's happy." One visitor told us, "Staff are really kind and caring and the youngsters are full of life."

Staff used opportunities to engage with people and help them solve difficulties with patience and kindness. People were offered assistance and reassurance in a manner that was positive and supportive. They listened to people and gave them enough time to express themselves or complete a task. Staff showed interest in what people had to say spoke to them appropriately and enabled them to understand and participate.

Staff knew people well and displayed a good understanding of the people they looked after and used this information whilst delivering care and support. Care plans were still being developed to reflect individuals. They contained a life history section which gave an insight into the person's life before coming to live at the

home. They were being developed with people and their families where possible. They contained some information staff could use to help build relationships, for example, people's previous occupations, hobbies their likes and dislikes. It was possible to 'see the person' in the care plans. One staff member told us about a person who appeared anxious and distressed on occasions. They told us how they supported them. They said when they provided care they explained exactly what they did. They said, "I explain every single thing, that way they know what is happening." We observed staff giving detailed instructions to this person and noticed this helped them to stay relaxed.

People were offered choices on how to spend their day. Where possible they were enabled to make safe use of all communal areas of the home. Where people had remained in bed or in their room they were now offered regular opportunities of visiting communal areas to meet people. Staff told us people could choose where to spend their day but for people who were less able to make decisions staff had done this based on their knowledge of people. They told us about one person who preferred a quieter environment but would spend the morning in the lounge and return to their room after lunch.

People's dignity was maintained by staff when they provided care to people in communal areas. They spoke discreetly when asking people if they needed the toilet and offered them choices. Some people needed to be moved with the support of a hoist. Staff explained to people what they were doing and offered reassurance throughout. People's privacy was maintained, staff knocked at bedroom doors before they entered and introduced themselves as they went in. Where people shared bedrooms care plans informed staff how to ensure their privacy was maintained, for example when providing personal care. This included the use of screens which were available in all the shared bedrooms.

People were involved in the development of a kitchenette in one of the lounges. People were asked what they would like to have and this included a kettle, chocolate biscuits and bright tins. There had been a ceremony with everyone invited to open the kitchenette. There were regular staff, resident and relative meetings and there was evidence that suggestions and comments were acted on.

Requires Improvement

Is the service responsive?

Our findings

We carried out an inspection on 3, 4 and 12 August 2015 here we found the provider had not met the regulations. This was because people did not always receive the care they needed or chose.

The provider sent us an action plan and told us they would address these issues by February 2016. At this inspection we found significant improvements had been made and the provider is now meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

Visitors told us their relatives received care that met their needs. One visitor told us, "My relative had a few falls at night when they first arrived. Staff sorted it out by changing the position of the bed and put pads at either side to monitor movement at night, they really care." Another visitor said, "Staff are very responsive to the individual needs of my relative." Visitors told us they had been involved in the development of people's care plans. One said, "I saw the care plan on admission, we discussed likes and dislikes but I don't think I have reviewed it since." Another said "I can check the care plan in the bedroom; it records if my Mum has eaten well etc."

People's needs had been assessed before they moved into the home. This was to ensure their needs and choices could be met. People's care plans contained information about their personal care, safety, mobility, skin integrity, nutrition and health. These had been developed with the person and where appropriate their representative. They included some information about the people's preferences, for example what they liked to eat and drink. Some care plans did not include detailed guidance about how to support people and there was limited information about what people liked to do each day and how staff could support them to continue with their interests. This had limited impact on most people. People received care that was person-centred because staff knew people well; they had a good understanding of people as individuals, their daily routine and likes and dislikes. For example, some people required support to maintain their continence. Care plans informed staff to ensure people were supported to use the toilet regularly but did not include further detail. Staff told us about one person who they would ask every four hours and after each meal if they wished to use the toilet. Staff understood the importance of good continence care in ensuring people's pressure areas were protected.

However, the care plan for one person who displayed behaviours that could challenge others and themselves contained limited information about the support they required in relation to their behaviours. Staff were able to tell us about the physical support needs of this person but not the behavioural, social and psychological support required. We observed staff supporting them but there was limited evidence of any positive engagement. For example we saw the staff member sitting with the person but they did not chat with them or try to engage them in any activities. We identified this with the provider and manager as an area that needs to be improved to ensure everybody received support that was responsive to their needs.

Despite these concerns staff had a good understanding of person-centred care. One staff member told us,

"Each aspect of each person's life is different we have that in mind". Another staff member said, "We try to make the care about the person." And a third staff member said, "It's the kind of care we would want for ourselves or our parents." There was an emphasis on getting to know and understand people as individuals and this was being promoted by the activities co-ordinator and through meaningful activities.

The opportunity to take part in activities that help to maintain or improve health and mental wellbeing can be integral to the promotion of wellbeing for older people. At the last inspection, we found concerns with the lack of opportunities for social engagement and activities for people.

At this inspection we saw an improved approach to the provision of activities, one to one sessions and social events for people. A new activities co-ordinator was in post and demonstrated commitment about developing and providing meaningful activities. A new approach was being developed using the Pool Activity Level (PAL) assessment. This is a framework for providing activity-based care for people who are living with dementia. The PAL assessment identifies a person's ability to engage in activities which are then developed for each individual; this included a detailed life-history and information about people's specific hobbies and interests. There was good interaction from staff as they supported people with activities throughout the home. The activities co-ordinator explained how they were working with people's families to discover the best ways of supporting each individual. He told us, "If it works, great but if it doesn't the next day we try something else." We were told about one person who liked routine and how staff were trying to introduce that back into the person's life. The person liked to be outside and as part of a routine they would top up the bird feeders in the afternoon. One person was distressed on occasions. Staff told us it was important to establish the reason for the distress and this was often due to their dementia type illness and what they "felt in their world at that time." Staff explained it was important to understand what was happening to people. One staff member said, "We encourage all carers to look under the surface."

Staff were enthusiastic about providing individual meaningful activities for people. A visitor told us, "Just lately they are doing a lot more. They are bringing my relative out of themselves." They also said, "My relative is thought and dealt with as an individual."

Not everybody had a PALS assessment however we observed an improvement in activities provided. One person's spiritual needs were being met by being supported to attend church. Other people had been provided with soft toys or dolls. We observed people showing interest and interacting with these items. Staff spent a lot of time talking to people, sitting with them and holding their hands. Some people liked to walk and we saw they were supported into the garden on one occasion. The activities co-ordinators encouraged people to be involved in everyday activities for example laying the table and folding napkins. We observed people being asked if they would like to do this throughout the inspection. There were pictures and photographs, some were specific to individuals but others were of significant historic events. We observed staff looking at and discussing these with people and supporting them to reminisce. Trips out had been arranged, this included a visit to the park for everyone who wished to go and two people had been out to choose linen for their bedrooms. Social occasions were held at the home to celebrate 'national days'. For example we saw people had been invited to attend a St Georges' day celebration.

There was a complaints policy at the home and this was on display in the reception area. Complaints were addressed as they arose and these were responded to in writing. We observed people and visitors approached the manager and provider when they had concerns. There had been a number of changes at the home in relation to the environment and activities. This has caused some concerns amongst visitors and relatives therefore the manager held a residents and relatives meeting where the changes were discussed. People and relatives were then invited to a further meeting when changes to activities would be discussed in depth.

In addition to regular resident and relative meetings people and relatives were able to feedback information and discuss concerns with the manager in a variety of ways. The manager had introduced written feedback forms where anyone could leave messages for her. We saw these were responded to. Improvements were being introduced to involve people and relatives in developing and reviewing care plans to ensure it met their needs and preferences. We observed people and visitors discussing their care and health needs throughout the inspection.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 3, 4 and 12 August 2015 we found the provider had not ensured that people were protected from unsafe care and treatment by the quality assurance systems in place.

Due to the concerns found at the last inspection, we determined people were at significant risk of not receiving safe care because the home was not well-led and the delivery of care was inadequate. The registered person had failed to notify the Care Quality Commission about any incidents that affected people who used the service. The provider sent us an action plan and told us they would address these issues by February 2016. At this inspection we found significant improvements had been made and the provider is now meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

At the time of the inspection there was no registered manager at the home. There was a manager in post who had submitted an application to register with the Care Quality Commission (CQC) and were registered shortly after 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.

We found that people's care plans did not always contain the information staff needed to look after people. For example care plans stated people needed to be turned regularly but the care plans did not state how often. When care plan reviews took place the information was not always used to update the care plan. Information from the falls risk assessments were not always included in people's care plans.
This did not impact on people because staff had a good understanding of their needs. Care plans did not always demonstrate people or their relatives had been involved in their development. However, through our discussions and observations we saw they were involved but this had not been recorded. We raised this with the manager who was aware of the concerns and working to ensure improvements were made.

There was an effective system to monitor the quality and safety of the service and make continuous improvements. A wide range of audits were carried out to monitor the quality of the service. Monthly checks were made of areas of the service, such as medicines, infection control and the safety of the premises to ensure that people were safe. The manager and provider were aware of the areas for improvement which we identified.

The manager, area manager and provider demonstrated strong values and a desire to ensure best practice throughout the service. There was a positive culture which encouraged staff to also strive for improvement. People were placed at the heart of the service and the manager placed emphasis on continuous improvement in all aspects of their care. The provider told us they wanted the home to be, "The best dementia care home around." Staff told us, "It's a lovely place to work."
Staff told us things had improved immensely at the home since our last inspection. A number of staff told us,

"If things hadn't changed I wouldn't still be here." One staff member said, "It's organised now, I know what I'm doing and I know who I need to report to." All staff spoke highly of the manager and one said, "She is amazing." The manager and provider acknowledged the recent improvements to the culture of the service. They told us they were working to ensure the changes were sustained and embedded into practice to make sure care remained person centred and regulations were met.

The manager had provided clear leadership for staff. They were involved and informed of the on-going changes at handover, staff meetings and through memos. Following an audit the manager shared analysis with staff and displayed memos to ensure all staff were informed. The memos also contained an action plan. For example the falls audit from April 2016 informed staff one person had been referred to the falls prevention clinic and the action plan reminded staff of their responsibility to check people and ensure appropriate equipment was in place. The manager also provided positive feedback for staff with a memo congratulating two staff members on examples of, "Excellent moments of caring."

The manager had also introduced measures to ensure people and relatives were involved in improving the home. There was a nutrition forum which involved the chef, a relative representative, a staff member who was a nutrition champion and other staff representatives. The forum had discussed a re-vamped menu and the importance of good nutrition.