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Downs Cottage Care Home (with Nursing)

Inspection report

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Date of inspection visit:
05 April 2016

Date of publication:
20 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Downs Cottage is a care home with nursing for older people including people who live with the experience of dementia and other mental health conditions. There were 13 people living here at the time of our inspection.

We previously carried out an unannounced comprehensive inspection of this service in June and July 2015. At those inspections a number of breaches of legal requirements were found. We met with the provider to discuss our concerns. We also issued two Warning Notices which required the provider to take immediate action in relation to staff training and the safety of the building.

Since our last inspection we have continued to engage with the provider. We also required the provider to submit regular action plans that updated us about the steps they had taken to improve the service. This inspection confirmed that the provider had taken the action they told us they had. Significant improvements to the way the home was being managed meant that the provider had complied with the Warning Notices we had issued.

Since our last inspection, the service had experienced a period of considerable change. Whilst it was evident that the management team had effected improvements to the home, these changes now needed to be embedded and sustained.

The providers focus had been on ensuring staff had appropriate training in first aid and changing the environment of the home to make it more suitable at meeting the needs of the people who live here. This included redecorating areas of the home, and major works such as installing two walk in shower rooms and fitting ceiling hoists to help people with mobility support needs. As such other areas of improvement had been identified, but not wholly implemented. For example, whilst we found that people received appropriate care, the care plans had still not been fully updated to give guidance to staff.

There was a registered manager in post. 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. However the registered manager had been absent from the home a number of times, and the provider's plans to give management support at the home were not totally successful. Staff had not had the opportunity to have formal one to one meetings with their manager as per the provider's policies. In addition a senior manager was not always available to support staff. The registered manager returned to work soon after our inspection, so these issues were in the process of being corrected.

We had positive feedback from people and their relatives about their lives at Downs Cottage. One person said, "I am happy here, I don't think they could do better." Another told us, "Staff are very nice and take time to talk to me." A relative said, "I think my family member is well looked after and happy living here." There

was positive and caring interaction between people and staff.

The home was decorated and adapted to meet people's needs. Flooring was smooth and uncluttered to aid with people's mobility needs. The home had an airy and homely feel.

People were safe at Downs Cottage because there were sufficient numbers of staff who were appropriately trained to meet the needs of the people who live here.

Risks of harm to people had been identified and clear plans and guidelines were in place to minimise these risks. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

Staff recruitment procedures were robust to ensure staff were suitable to support people in the home. The provider had carried out appropriate recruitment checks before staff commenced employment.

People received their medicines when they needed them. Staff managed medicines in a safe way and were trained in the safe administration of medicines. All medicines were administered and disposed of in a safe way.

In the event of an emergency people would be protected because there were clear procedures in place to evacuate the building. Each person had a plan which detailed the support they needed to get safely out of the building in an emergency. The premises were safe to use for their intended purpose.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Staff were heard to ask people for their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. One person said, "The food is nice, I like it all." A relative said, "My family member loves her food, and even though she has to have it pureed, she comes back for seconds because it is so nice."

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. When people's health deteriorated staff responded quickly to help people and made sure they received appropriate treatment. A relative said, "My family member had an infection recently, staff care and support helped him to get better."

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection, such as staff talking with them and showing interest in what people were doing. People looked relaxed and happy with the staff. People could have visitors from family and friends whenever they wanted. The staff knew the people they cared for as individuals, and had supported them for many years, giving a family feel to the home.

Care plans were based around the individual preferences of people as well as their medical needs. They gave a good level of detail for staff to reference if they needed to know what support was required. People received the care and support as outlined in their care plans. Details such as favourite foods in the care

plans matched with what we saw on the day of our inspection. People had access to activities that met their needs.

People knew how to make a complaint, and told us that the registered manager would always listen to what they said and take appropriate action to put things right. Staff knew how to respond to a complaint should one be received.

Quality assurance records were kept up to date to show that the provider had checked on important aspects of the management of the home. The registered manager had ensured that accurate records relating to the care and treatment of people and the overall management of the service were maintained. Records for checks on health and safety, infection control, and internal medicines audits were all up to date. Accident and incident records were kept, and were analysed and used to improve the care provided to people. The provider regularly visited the home to give people and staff an opportunity to talk to them, and to ensure a good standard of care was being provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was safe.

There were enough staff to meet the needs of the people. Appropriate checks were completed to ensure staff were safe to work at the home.

Staff understood their responsibilities around protecting people from harm.

The provider had identified risks to people's health and safety with them, and put guidelines for staff in place to minimise the risk.

People felt safe living at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had access to training to enable them to support the people that lived there. However the absence of the registered manager meant that staff had not had supervisions or appraisals in line with the provider's policies.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health improved as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff that showed respect and care.

Staff knew the people they cared for as individuals. Communication was good as staff were able to understand the people they supported.

People could have visits from friends and family whenever they wanted.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and gave detail about the support needs of people. People were involved in their care plans, and their reviews.

People had access to a range of activities that matched their interests. People's access to the local community could be improved.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received.

Is the service well-led?

Requires Improvement

The service was not always well- led.

The registered manager had been absent from the home, and the management cover had not been completely successful in supporting staff, and ensuring actions identified to improve the home were completed in good time.

Quality assurance records were up to date and used to improve the service, however these were not always available when requested.

People and staff were involved in improving the service. Feedback was sought from people via an annual survey.

The registered manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Downs Cottage Care Home (with Nursing)

Detailed findings

Background to this inspection

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

This inspection took place on 5 April 2016 and was unannounced. Due to the small size of this home the inspection team consisted of one inspector and a nurse specialist.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed to see if we would need to focus on any particular areas at the home.

To find out peoples experiences living at the home we spoke with four people, four relatives, and five staff, which included the providers representative who was there in place of the registered manager. We sat with people and engaged with them. We observed how staff cared for people, and worked together. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. The local authority and safeguarding team did not identify any recent concerns about the home.

We also reviewed care and other records within the home. These included three care plans and associated records, three medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspections in June 2015 and July 2015 we had identified a number of concerns at the home. These had been addressed by the time this visit took place.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in July 2015, we found that people were not kept safe following a death at the home. There were concerns people were not kept as fire safety concerns identified in risk assessments and Surrey Fire Safety Officer reports had not been fully addressed. As such we issued a Warning Notice for the provider to make immediate improvements in this area.

As a result of our previous inspection findings, the provider had instigated additional management oversight at Downs Cottage. They also supplied us with regular updates that highlighted their progress against an action plan of required improvements. Improvements had been made and further plans for positive change had been identified. The home now required a period of stability for these changes to be embedded and sustained.

At this inspection we found that people were now safe living at Downs Cottage. A relative said, "I feel it is very safe here, because of the way staff are with people." Another said, "My family member is always relaxed; I have never seen anything to give me concerns." The registered manager and provider had taken appropriate action to address the two concerns we had raised in July 2015.

At our previous inspection in June 2015the home was not consistently clean nor was it well maintained. At this inspection people were cared for in a clean and safe environment. A relative said, "They have decorated the sitting room, and replaced a lot of the flooring. We have never noticed any unpleasant smells when we have visited." The risk of trips and falls was reduced as flooring had been replaced in many parts of the home. This also helped to reduce the risk of unpleasant odours as the new flooring was easy to clean. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control, and fire safety. The registered manager had regularly reviewed the needs of people to ensure the environment met their needs.

People were protected from the risk of abuse. Staff had a clear understanding of their responsibilities in relation to safeguarding people. Staff were able to describe the signs that abuse may be taking place, such as bruising or a change in a person's behaviour. They understood that all suspicions of abuse must be reported to the registered manager, or person in charge. Staff understood that a referral to an agency, such as the local Adult Services Safeguarding Team or police should be made, and that they could do this themselves if the need arose. Information about abuse and what to do if it was suspected was also clearly displayed in the entrance hall for people and visitors to see, so they would know what to do if they had concerns.

There were sufficient staff deployed to keep people safe and support the health and welfare needs of people who lived at the home. At our previous inspection in June 2015 we recommended that the provider review staff deployment, as there were times when the communal area had no staff cover, leaving people at risk of falls. During this inspection a relative said, "There are always enough staff when we come. They don't put anything on, as they don't know when we are coming." Another said, "There are always two staff when they lift people." Staffing rotas showed that levels of staff on shift over the past four weeks matched with the

calculated support levels of the people that lived here.

Staffing levels were calculated on the needs of the people who lived at the home. The provider carried out an assessment of people's support needs prior to them coming into the home to ensure these needs could be met. This was reviewed annually, or if a person's needs changed (such as illness), or if more people moved into the home to ensure people's needs were met. Staff felt there were enough staff. Their replies to our question were positive and they felt there were enough to offer a good service to people. This matched with what we saw on the day of our inspection.
Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the manager to look for patterns that may suggest a person's support needs had changed.

People were kept safe because the risk of harm from their health and support needs had been assessed and action taken to minimise those risks. A relative said, "My family member did have a choking incident last year. Staff dealt with this effectively at the time." The person had a referral to a Speech and Language Therapist, and as a result was put on a pureed diet to reduce the risk of choking. People who spent time in bed where seen to be supported to a sitting position when staff supported them to eat, in line with guidance to minimise the risk of choking. One staff member said, "We keep an eye on the residents all the time. We act upon what we see; we look at the risk assessments." Another said, "We use hoists and slide sheets to help people move. We have two staff to help with moving residents." Assessments had been carried out in areas such as nutrition and hydration, mobility, and behaviour management. Measures had been put in place to reduce these risks, such as specialist equipment to help people mobilise around the home. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs.

Where people were at risk of pressure sores, they received effective care to keep them healthy; however one area for improvement was identified. People had access to the GP and tissue viability nurse, and wound dressings were changed daily in accordance with their instructions. Records of people who stayed in bed being turned to reduce the risk of a sore occurring were also up to date and complete. However two pressure mattresses to reduce the risk of sores developing were not set to the correct setting to match the person weight. One was set to low, the other was too high. Apart from this error, both people had received effective pressure wound care. It is recommended that the provider review how they control and check pressure mattress settings to ensure they match the manufacturer's recommendations.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff in fire evacuation plan. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely.

People's medicines were managed and given safely. At our previous inspection in June 2015 we recommended that the registered manager review best practice guidelines as issued by the National Medical Council with regards to dispensing of medicines. People were given time and support by the nurse to take their medicines to ensure that it was taken safely. Staff that administered medicines to people received appropriate training, which was regularly updated. Staff who gave medicines were able to describe

what the medicine was for to ensure people were safe when taking it. For 'as required' medicine, such as pain relief there were guidelines in place which told staff when and how to administer the pain relief in a safe way.

The ordering, storage, recording and disposal of medicines were safe and well managed. There were no gaps in the medicine administration records (MARs) so it was clear when people had been given their medicines. Medicines were stored in locked cabinets to keep them safe when not in use. Clear and safe systems were in place with regards to the disposal of unused medicines. This included collection by the pharmacy, and the use of specialist equipment to render the unused medicines unusable by anyone else. Staff were seen to follow these guidelines.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in June 2015, we found that the environment was not appropriate in meeting the needs of the people who lived there. As such, we made it a requirement that the provider took action to ensure care was provided in a way that met people's needs.

At this inspection in April 2016 the environment had been modified to some extent to meet people's needs. Bathrooms had been adapted to better suit people with mobility support needs. Two of the four bathrooms had been converted to walk in shower rooms, so people could have a shower without the need to be hoisted. Ceiling hoists had also been installed in the lounge areas to help people get into and out of chairs more safely. The provider had completed the adaptations to meet peoples physical support needs, however the adjustments to better suit the needs of people living with dementia were ongoing at the time of this inspection.

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. The provider had a clear training plan in place for each staff member to keep them updated in current best practice. Staffs knowledge around people's support needs was good. However we did identify that there was some confusion amongst the nursing staff on frequency of blood checks for one person with diabetes. These had been done at a higher frequency than the person's condition indicated was required. The records about why this was being done were also unclear. The frequency of blood testing had been reduced to weekly, but the nurse in charge felt this was more of a 'guideline' so had on occasion tested the blood more frequently. This was done to check that the person's blood sugar had not become too high, but there was no clear plan in the notes to say what the blood glucose test was looking for, or why the additional test had been done. It is recommended that the provider review with nursing staff best practice in testing bloods of people with diabetes.

Staff were not completely supported at the time of our inspection. Staff told us that due to the absence of the registered manager they had not had formal one to one meetings, nor had they had an appraisal to discuss their goals. Shortly after our inspection the registered manager returned to work, and action was taken to address these issues.

At our previous inspection in June 2015 we recommended that the provider review care files to ensure they clearly document mental capacity assessments for specific decisions. This had now been completed. 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.

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. The provider had complied with the requirements of the Mental Capacity Act 2005 (MCA). Where people could not make decisions for themselves

the processes to ensure decisions were made in their bests interests were effectively followed.

Staff had a good understanding of the Mental Capacity Act (2005) 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 were able to demonstrate how it had been used to ensure a person's human rights were not ignored. One staff member said, "The MCA is about someone's ability to make decisions around their life." Staff were seen to ask for people's consent before giving care throughout the inspection.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). CQC is required by law to monitor the operation of the DoLS, and to report on what we find. Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

People had enough to eat and drink to keep them healthy and had good quality, quantity and choice of food and drinks available to them. One person said, "The food is nice, I like it all." A relative said, "My family member loves her food, and even though she has to have it pureed, she comes back for seconds because it is so nice."

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. People at risk were on fluid balance and food charts, to monitor that they are getting enough of both. These were seen to be completed at the time staff supported people to eat and drink, which ensured they gave an accurate and timely record that people's needs had been met. People's weight was monitored and recorded monthly, and these showed that peoples weights were stable, indicating they were getting enough to eat and drink.

Lunch was observed to be a quiet and dignified event. Staff had friendly interaction with people during the meal and made it an interactive and positive experience for everyone involved.

People's special dietary needs were met. People's preferences for food were identified in their support plans. Where a specific need had been identified, such as food presented in a particular way to aid swallowing, this was done. Staff were able to tell us about people's diets and preferences. Menu plans, and food stored in the kitchen matched with people's preferences and dietary needs and showed they had the food they needed.

People received support to keep them healthy. A relative said, "My family member had an infection recently, staff care and support helped him to get better." Another said, "My family member had a urinary tract infection, and the staff called in the GP quickly. They kept us updated and my family member got better." Staff were effective at noticing changes in people's health. On the day of our inspection care staff noticed that a person was not their usual self. They asked if they were alright, and if they wanted to see the nurse. The nurse came and spoke to him, and she then arranged for him to see the GP.

People had regular access to health care professionals. Each person had a health action plan in place. This detailed when they had check-ups, and how often these should be done. Information about the outcome of the appointments and any action needed by staff were also clearly recorded and followed. Where people's health had changed appropriate referrals were made to specialists to help them get better. One person had recently had a visit from a GP, and the nurse fed back to the chef the results of the checks, and how this

would affect the person's diet.

Good

Is the service caring?

Our findings

We had positive feedback about the caring nature of the staff. One person said, "I am happy here, I don't think they could do better." A relative said, "Everyone cares and knows about my family members condition. I do feel staff know his life history." Another relative said, "The staff are really lovely people." Another said, "Staff are lovely, very friendly and great with family, and the other residents who live here."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. When people became agitated staff spoke calmly to them and defused the situation, so others were not affected. People looked well cared for, with clean clothes, tidy hair and appropriately dressed for the activities they were doing.

Staff were very caring and attentive with people. One person said, "Staff are very nice and take time to talk to me." The nursing and care knew about each person and talked fondly about some of their habits, preferences, and their relatives. Throughout our inspection staff had positive, warm and professional interactions with people. All the care staff were seen to talk to people, asking their opinions and involving them in what was happening around the home, one staff member sat with a person and complimented them on their clothing and how smart they looked, the person responded positively to this by smiling. Care records recorded personal histories, likes and dislikes, and these matched with what staff had told us. Throughout the inspection it was evident the staff knew the people they supported.

Staff communicated effectively with people. When providing support staff checked with the person to see what they wanted. Staff spoke to people in a manner and pace which was appropriate to their levels of understanding and communication. People were involved in their day to day care and support needs. One person was looking that the television which was turned off. Staff noticed and asked if he wanted it turned on. They did this then spent time talking to him to make sure he was happy with the programme that was on. They also ensured he had access to the TV remote so he could change programmes if he wished.

Staff treated people with dignity and respect. Staff were very caring and attentive throughout the inspection, and involved people in their support. Examples such as asking people for permission before they were moved in their chairs were seen throughout the inspection from all staff. When giving personal care staff ensured doors and curtains were closed to protect the person's dignity and privacy. When supporting people to eat in bed they sat facing the person, talking to them and took time with them. We saw many acts of kindness and gentleness from the way care staff responded to people. Care staff were patient, friendly and warm with people.

People's independence was promoted as much as possible by the staff. This was mainly shown during meal times were each person had the support they needed to eat. Those that were able to had food presented on china plates and fed themselves. Others had plates with a lip on, to make it easier for them to pick up food from their plate without staff help. Another example was by encouraging people to maintain their mobility. One person was supported by staff to walk to the bathroom, rather than use a wheelchair (which would have been the quick and easy option for staff). They explained to the person why it was important for them

to walk - to maintain their mobility.

People were given information about their care and support in a manner they could understand.

People's rooms were personalised which made it individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to places of worship in the community so they could practice their faith.

Family members were able to keep in regular contact and visit whenever they liked. They were able to meet family members in private if they wished. One relative said, "Sometimes we go into the quiet lounge if the main lounge is very busy."

Good

Is the service responsive?

Our findings

At our previous inspection in June 2015, we found that people did not always have their individual needs regularly assessed, recorded or reviewed. At this inspection we found that people's care was better planned and that they received support in a way that was responsive to their changing needs.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. A relative said, "When she first came here we all sat down and made decisions and put a care plan into place." These assessments contained detailed information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility.

People and relatives were involved in their care and support planning. Where people could not be involved themselves, relatives or advocates were involved. One relative said, "They are really good at informing us of falls, or other things that may affect my family member." Another said, "We are always invited to care reviews." Care plans were based on what people wanted from their care and support. They were written with the person by the registered manager or key worker. A key worker is a member of staff identified to be the main point of contact for a person who uses the service. The daily plan of care records guided staff on what support people needed, as well as clearly stating what the person could do for themselves. This included guidance such as explaining the task that was about to be done with the person, and give them a chance to participate and do as much as they can for themselves.

People's choices and preferences were documented and those needs were seen to be met. One relative said, "They always hang my family members clothes up neatly, and make sure she has her hair done, which she loves." There was detailed information regarding people's likes and dislikes and the delivery of care. The files were well organised so information about people and their support needs were easy to find. The files gave a clear and detailed overview of the person, their life, preferences and support needs. Care plans were comprehensive and were on the way to being person-centred, focused on the individual needs of people. People received support that matched with the preferences record in their care file.

Care plans addressed areas such as how people communicated, and what staff needed to know to communicate with them. Other areas covered included keeping safe in the environment, personal care, mobility support needs, behaviour and emotional needs. The information matched with that recorded in the initial assessments, giving staff the information to be able to care for people.

At our previous inspection in June 2015 People did not have access to activities that interested them. People now had access to a range of activities; some of them group based, but also individual activities, based around people's needs. An activities coordinator had been employed and provided support to people to play games and do exercises each day. People enjoyed the games and quizzes and the activities coordinator made sure that everyone was invited to take part. Some work had been done to support the activity needs of people who lived with dementia. An artificial baby had been purchased and one person showed an interest whenever they were asked if they would like to look after it. This gave stimulation to the person and jogged their memory. During the activities people's faces lit up and enjoyed the praise given by the activities

coordinator and care staff when they were successful at a task. This included people that had previously been dozing in their chairs, as the activity woke them up and they smiled and laughed as they took part.

Staff said there was no reason why people could not take part in activities outside the home but that, "The residents seemed to be very happy to stay within the home." Currently the activities are group based and it is recommended that the provider look at more individual activities that may interest people. Also people may benefit from access to the local community or trips out.

People were supported by staff that listened to and responded to complaints or comments. One person said, "If I was unhappy they would make things better." A relative said, "I would speak to the manager, but I have never had any concerns about the care here." There was a complaints policy in place. The policy included clear guidelines, in an easy to read format, on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

There had been no complaints received at the home since our last visit. The staff explained that complaints were welcomed and would be used as a tool to improve the service for everyone.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2015 we had identified three areas which the provider needed to improve. We made it a requirement of that the provider took appropriate action to ensure that care was provided in a way that met people's needs. The three areas for improvement were: People and relatives were not included in how the service was managed; The results of audits and performance reports were not always respond to to address the issues that were raised; and records of care given to people were not detailed to show that people had received appropriate support.

As a result of our previous inspection findings, the provider had supplied us with regular updates that highlighted their progress against an action plan of required improvements. The home now required a period of stability for these changes to be embedded and sustained.

There was a positive culture within the home between the people that lived here, the staff and the manager. A relative said, "Staff work well together here." Another told us the atmosphere of the home was, "Chilled, calm, friendly and warm." They went onto say, "I think the home is well led, everything is done on time and it feels like it is smooth sailing." The management representative had a good rapport with relatives and people, demonstrating that he knew them and was available to talk to if they wished to raise anything with him.

Staff enjoyed their job, but concerns were raised about the overall management of the home The registered manager had been absent due to a number of periods of sickness over the last nine months. Management cover was intermittent and actions to improve the home, and support staff were delayed. The registered manager was away on the day of our inspection, and it took some time for a management representative to come to the home to give us access to certain staff records. In addition the management representative was unable to locate key documents such as results of audits at the time of the inspection. These were supplied after the inspection.

Records management had improved since our last inspection, however work was still being done to further improve the quality of the care plans, such as ensuring all gaps were completed so staff had all the information they needed to be able to provide a good standard of person centred care.

Senior managers were involved in the home because the provider carried out regular visits to check on the quality of service being provided to people. The registered manager also completed a monthly report to keep the provider up to date on what had happened at the home, and to monitor that a good standard of care and support where being given.

Records demonstrated that where actions had been identified, the registered manager had taken action to correct the issue. Regular monthly checks on the quality of service provision took place and results were actioned to improve the standard of care people received. Audits were completed on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. All of these audits generated improvement plans which recorded the action needed, by whom and by when. Actions

highlighted were addressed in a timely fashion.

People and relatives were included in how the service was managed. The registered manager ensured that various groups of people were consulted for feedback to see if the service had met people's needs. Relatives told us they had the opportunity to talk with the registered manager if they wished, and that the communication from the home was good.

Staff felt supported and able to raise any concerns with the manager, or the provider. Staff understood what whistle blowing was and that this needed to be reported. They knew how to raise concerns they may have about their colleague's practices. Staff told us they had not needed to do this, but felt confident to do so. Staff were involved in how the service was run and improving it. Staff meetings took place and any issues or updates that might have been received to improve care practice were discussed. Further work was being carried out by the provider to encourage staff to be more involved in the meetings and how the home was managed.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns. They had also completed the Provider Information Return when it was requested, and the information they gave us matched with what we found when we carried out this inspection.