Bakewell Cottage Care Home Limited

Bakewell Cottage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bakewell Cottage Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide care for 38 people, at the time of our inspection there were 36 people living there. People were accommodated in single rooms across three floors within the building. There were two lifts within the building.

There was a registered manager in post at the time of our 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.

The inspection visit took place on 18 and 23 April 2018; the first day was unannounced. The timing of the second visit was agreed with the registered manager in advance. The service was last inspected in 2016, when it was rated good. At this inspection the service was rated overall as Requires Improvement; however it was rated good in caring and responsive as an acknowledgement of the caring nature of the staff. This is the first time the service has been rated Requires Improvement.

We identified three breaches of regulation at this inspection. You can see what action we told the provider to take at the back of the full version of this report.

The service was not always safe. Risk assessments were not always in place or were not always followed consistently. Information regarding known risks to people was not always shared with relevant people or agencies and we found a safeguarding referral had not been made when required. Some people were at risk of receiving ineffective medicines or not receiving 'as required' medicine to treat occasional symptoms, due to poor management of medicines.

Staff were skilled and knowledgeable about people's care needs. People generally received effective care that met their individual needs. People received a varied and nutritionally balanced diet and independent eating was supported wherever possible. People had access to specialist and local healthcare services to support them to live healthier lives. Specialist aids were available to promote peoples independence and safe mobility. However, the registered manager did not always follow the principles of the Mental Capacity Act and could not always assure us that restrictive care was provided in people's best interest or the least restrictive option.

People and their relatives were overwhelmingly positive about the kindness and compassion of the staff. Relatives said their loved ones were well cared for and staff treated them with respect and dignity. Choice and independence were promoted and people were involved in making decisions about their daily activities

and their care.

Staff were responsive and had a good understanding of people's needs, preferences and interests. We saw people engaged in activities of their choosing and spending time with their visitors in the privacy of their room or in the communal areas and garden. There was a complaints policy in place and relatives told us they would not hesitate to use it. There had only been two complaints recorded in the last 12 months. Staff supported people and their families with dignity and sensitivity at the end of their life and assured us their wishes and preferences were considered.

The registered manager was respected by people, relatives, health professionals and staff. People described the registered manager as firm but fair and always having the interests of people at the centre of what they did. There was a clear vision and focus on dignity, independence and personalised care and this was supported by the staff team. There were strong productive links with local services and agencies which led to joined-up care of people, as well as positive links with local community services and facilities, which led to a varied activity programme.

However, the governance and quality assurance systems in place were not robust or used effectively to analyse information and improve the service. This made it difficult to evidence achievements and positive outcomes or identify areas for development. Audits and policies were not robust, staff engagement and supervision was not consistent and provided little evidence of progression or development needs. It was not clear how the views of others influenced service development. Information was not always shared with relevant agencies in order to keep people safe and notifications were not always sent to CQC as required under the terms of registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were not always completed or followed. Information regarding known risks to people was not always shared with relevant agencies.

People generally received their medicines as prescribed, but poor record keeping meant the service was not able to demonstrate that medicines were always managed safely.

Staff understood how to prevent and control infection. Staff were not always deployed effectively to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff clearly knew people's care needs and had the knowledge and skills to care for people. However, the staff induction and supervision process would benefit from some structure and more effective record keeping.

People had access to a varied and nutritional diet that considered personal preferences and choice. Consent for daily care and activity was obtained by staff.

However the service did not always follow the principles of the Mental Capacity Act regarding consent and best interest decisions, for people who lacked capacity to make decisions for themselves.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and compassionate. Staff supported people to express their views and preferences.

People and staff developed positive relationships based on dignity, independence and respect.

Is the service responsive?

Good

The service was responsive.

Staff clearly understood people's preferences and choices and respected these.

People and their families, where appropriate, were involved in planning their care and agreeing their daily activities.

People received dignified and sensitive care at the end of their life; and families were encouraged to be involved as much as they wished.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The governance and quality assurance systems in place were not always effective at identifying areas for development and it was not clear how the views of others influenced development of the service.

The registered manager did not always notify relevant agencies of incidents that put people at risk of harm, including safeguarding's. They did not always send us notifications as per the terms of their registration.

The registered manager was respected by people, relatives and staff. They had positive relationships with local agencies and used these relationships to ensure the best care possible for people who lived at the home.

Bakewell Cottage 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 inspection took place on 18 and 23 April 2018. The inspection team consisted of one inspector, one inspection manager and one specialist professional advisor, who was a nurse with experience of caring for older people.

Before the inspection visit we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We also reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

In order to make an informed assessment of the quality of the service, we looked at a variety of records, spoke to people and observed practice during our inspection visits. Before the inspection visit we spoke to external people associated with the service. For example, we contacted commissioners, health practitioners and other monitoring bodies, who have contact with the service or the people that live there. We also reviewed the carehome.co.uk website to review feedback left by people, or families of people who have used the service. We spoke to 10 people who used the service or their families; as well as the registered manager and seven staff. We viewed eight care records and looked at needs and risk assessments, daily care logs and referrals. We viewed management records which included four staff records, policies, quality assurance records, meeting minutes, along with evidence of induction, supervision and training. We asked the provider to email us further information regarding particular policies, staff training, supervision and

minutes of staff meetings. These were sent promptly and within the timescale requested.

Requires Improvement

Is the service safe?

Our findings

We saw risk assessments were generally in place for personal care and were documented in people's care plans. However, we found some care plans where risk assessments were either not in place or not followed consistently. For example, there was no risk assessment in place for a person who used oxygen in their room, which meant it was not clear how staff ensured the equipment was used safely. We saw many of the people living on the ground floor had stair gates at the entrance to their rooms. The registered manager told us, this was at the request of people or their relatives and was to prevent people from entering their room and moving things around, rather than to prevent them leaving their own room. However, we found this was not clearly explained in people's care plans and there were few risk assessments in place which had identified and mitigated any risks to individual people, from having the gates in place. For example, we saw one person struggling to open their gate as they tried to leave their room for over 10 minutes, before a staff member arrived to assist them. During this time the person became distressed and had pushed their foot through the gate and their slipper had fallen off. This increased their risk of falling.

We saw another resident in this person's room, which meant the gate, had not been effective at keeping people out. A staff member said the person who lived in this room regularly walked around the building and could usually manage the gate themselves; however they did not always shut it behind them, which meant that other people could then walk in. We could not find this information recorded on their care plan or risk assessment which meant that both assessments were not accurate or effective at keeping this person or their belongings safe.

During the inspection visit we heard a person calling for help on numerous occasions. We visited this person's room twice when staff had not responded to their calls, where we found them attempting to walk around their room or to the toilet. This person's care plan and risk assessment identified that they lived with dementia, were at high risk of falls and used a walking frame to assist them when walking. It also stated they did not understand or remember to use their call bell when they needed assistance and would shout for help when required. To mitigate the risk of falls, the risk assessment said there was a sensor mat in place which would alert staff to this person trying to mobilise themselves; and staff would check on them every 30 minutes, when they were alone in their room. When we visited this person's room there was no sensor mat in place, they were alone and they were attempting to walk without their walking frame. As staff had not responded to their calls for help, we used the call bell to alert staff to their need for assistance. The staff member who arrived said they thought a relative was visiting which is why they had not checked on them as frequently as suggested in the care plan. When we discussed this with the registered manager, they could not explain why the sensor mat had been removed and said a relative usually visited every afternoon and staff were not aware that this was not the case on this particular day. This demonstrated the processes and risk assessments in place were not always effective in keeping people safe and known risks to people were not safely managed, resulting in people being at risk of harm.

Information about known risks to people including safeguarding was not always shared with relevant agencies. For instance, there had been no referrals to safeguard people from known risks from unwanted visitors. This meant the registered manager did not always follow the processes in place to keep people safe

from known risks.

During our inspection visit we noticed that the front door was either open or unlocked allowing visitors' unchallenged access to the building and opportunity for people to leave the building unnoticed. The registered manager said people who were known to be at risk from leaving the building unaccompanied, wore a 'Wanderguard Bracelet' which alerted staff if they tried to go out of the front door. They also said there was usually someone about to see visitors arriving and regular visitors knew they had to sign the visitors' book, which was usually hung up by the door in the reception area or kept in a drawer to keep safe. However, there had been no staff around when we entered the building for our inspection and we saw other visitors arrive and go straight to their family member's rooms, without seeing any staff. One relative told us that they were often in the building and staff did not know they had arrived. In view of the identified risks to people from unwanted visitors and the assumptions that were made about whether visitors were in the building and 'keeping an eye on people', we found this arrangement to be unsafe and in need of review.

Some people had equipment or aids available to keep them safe from known risks, for example walking frames, hoists and wheelchairs. We found that these were maintained and fit for purpose. However, we found the equipment available was not suited to the needs of some people and was less effective in keeping them safe. For example, some people had dementia and could not remember how to use the call bell in their rooms; some people moved the sensor mats away from their chairs or avoided stepping on them; and one person frequently opened the emergency exit doors which set an alarm off, which meant the 'Wanderguard Bracelet' was not effective near those doors. In these incidences the only alternative in place was for staff to make frequent checks on people throughout the day and night. However, these checks were not always recorded so there was little evidence that they actually took place. Staff also relied on visitors to alert them if people required assistance.

People told us they received their medicines on time; and we observed medicines administered safely to people during our inspection visit. We checked the associated medicine administration records and found they were completed correctly. However, we found medicines were not always consistently well managed. We found examples of fridge temperatures not being recorded daily, as is required to ensure they are stored at optimum temperatures to remain effective. We found 'as required' (PRN) medicine protocols were not always available where required, which meant staff did not always have information to support them to decide when to administer PRN or what to do if it was not effective. We also found medicine that was administered by 'patches' applied to the body, were not always placed and rotated according to manufacturer's instructions. This meant they were not always effective and could affect a person's ability to absorb the required dosage. Medicines were not consistently well managed to ensure people received maximum benefit from them.

We found few examples of changes to practice or learning from incidents, throughout our inspection. We reviewed the 'monthly falls audit' for January, February and March, which identified how many falls people had each month, as well as where and when they occurred. However, there was no evidence to show how this information fed into people's care plans or risk assessments. It was not clear the management team identified any themes or trends from this audit and how this was used to improve care and keep people safe from known risks or incidents. We 'case tracked' one person who had 11 falls in this quarter and found that although the falls had been recorded in their care plan, this information had not been analysed and used as an indication of how this persons condition was progressing or when this person was most vulnerable to falling. We felt the service was missing opportunities to improve people's care by not consistently analysing information available to them which could help them understand individual changing needs and document this clearly.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

People told us they felt safe living at Bakewell Cottage Care Home. One person said, "The staff are really kind and I do feel safe here." Relatives we spoke to were full of praise for the home and felt their family members were much safer here than at their own home. One relative said, "I know they are safe here, it's such a relief." Another said, "My family member has never expressed concerns or appeared scared. I know they feel safe and cared for." Staff we spoke to understood how to keep people safe from abuse and were able to explain the processes they would follow, if they were concerned. We saw safeguarding and reporting policies were in place to support staff with this. There was a whistleblowing policy and staff told us they would not hesitate to use it if they felt a person was at risk.

People and their relatives told us the registered manager employed 'very good staff'. One person said, "She only takes the best," and a relative said, "The staff are brilliant, the manager is very particular about who she takes on and it shows."

People and their relatives told us there were enough staff. One person said, "They come quickly when I want help" and a relative told us, "Yes, there are enough staff, they come quickly." Staff told us that generally there were enough staff but there were times when they said they would welcome some more. One staff member told us " It's usually OK, but we have a lot of people with dementia and if staff are off sick, or if a person is distressed and presenting with challenging behaviour, we could always do with another pair of hands." This person also said, "If we're fully staffed we usually have time in the day to spend one-to-one with people, which is nice. This is when we really get to know them." We reviewed the rota and found it to be mostly consistent with the numbers of staff the registered manager had said were required to care for people, depending on their need. The registered manager also told us that there were, "Plenty of ancillary staff to support care staff if needed."

Although there appeared to be the agreed number of staff on duty during the inspection visits, we found there were periods when staff were not available to assist people. For example, in addition to the previously stated incidents, we felt the need to call for assistance from staff, to attend to a person who required support in the dining room and was distressing other diners. This demonstrated that staff were not always deployed effectively to maximise people's safety or meet their needs.

The home was clean and clear of clutter when we visited. We saw housekeeping staff cleaning beds, changing bedding and attending to laundry. Where people had contagious infections the rooms were clearly signed to alert visitors and staff to take extra precautions by wearing gloves and aprons. Staff told us there was separate laundry and waste disposal arrangements for such people to prevent cross contamination. This was recorded in people's care plans. There were hand washing solutions available throughout the building for staff and visitors to use. There had been a recent outbreak of the 'winter flu bug' when many people and staff had become sick. Staff told us that extra precautions were taken to reduce the risk of cross contamination and families were asked not to visit. This was confirmed by relatives who said this was particularly hard as it started on Christmas Eve, which meant they were unable to see their family members over Christmas. The registered manager had notified the relevant authorities of the outbreak and followed guidance and best practice in order to contain the infection.

We reviewed infection and prevention control (IPC) guidance and found it gave clear advice in the event of an outbreak of an infection within the home. We saw minutes of the last nurses meeting in January 2018, which was after an outbreak of a sickness bug. This meeting covered best practice when there was an outbreak of sickness within the home and who to inform or contact for advice. The only IPC audit we saw

was for hand washing and only covered four staff. We considered this to be basic and incomplete. However, staff told us they had completed training on IPC and found it useful and we saw records that evidenced this. Relatives commented there were 'no offensive odours' in the home and we noted few odours during our inspection, with the exception of lunchtime when the toilet opposite the entrance to the dining room was used for people. When we mentioned this to staff who were standing outside the toilet serving food from a hot food trolley, they said they would encourage people and staff to use another nearby toilet in future during meal service, to respect people's dignity.

The service had been awarded a five star hygiene rating for its kitchen facilities. We found the kitchen to be clean and organised during our inspection visits, with fresh food and meat stored separately from cooked food and tinned produce. Staff preparing food had relevant training and certificates in place.

Requires Improvement

Is the service effective?

Our findings

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. We found DoLS were in place for some people who required restrictive care to keep them safe; and applications to authorise DoLS had been sent to the relevant 'supervisory body' for other people who required them.

We checked if the registered manager was complying with the conditions set by the 'supervisory body' (in this case the local authority) for an appropriate advocate to be involved in planning a particular person's care; but we could not find evidence that this condition was being met. This evidence was supplied to us on the second day of inspection. The registered manager had not sent us the required notifications to advise us of the DoLS that had been authorised. They told us they were not aware it was a requirement to do so. Therefore we were not aware of the restrictions that were in place for some people. Notifications were subsequently sent and were received by CQC on 20 April 2018.

When people do not have capacity to make decisions themselves, any decisions must be made by people who know them and must be in their 'best interest'; for example relatives and professionals who care for people. They must be recorded as such and give clear justification as to why the decision had been made. We found that decisions made in people's best interest were not always clear or were not recorded. For example, there were few recorded best interest decisions for people who had a stair gate fitted to their rooms. We also found that relatives made decisions about their family members care when they had no legal authority to do so; for example in the absence of a legally authorised power of attorney. For example, one person who had fluctuating capacity deferred to their relative to make decisions on their behalf; however, this was not clearly documented and therefore had no legal basis. This meant staff were at risk of providing unauthorised restrictive care and not following the principles of the MCA.

There were inconsistencies in how the MCA and 'best interest' decisions were applied. This is a Breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – consent.

We saw some care records contained reference to NICE guidelines; for instance, when caring for a person with an infection. This meant that staff had considered good practice and evidence-based guidelines when planning people's care.

The registered manager told us care plans were reviewed monthly or when a person's needs change. We

saw evidence of monthly reviews in some care plans but there was no evidence of reviews in all the care plans we reviewed. For example, we reviewed the care plan for one person who was identified at high risk of falls and had falls recorded for each of the previous three months. We found no evidence in their care plan that this had been reviewed to see if there was a need to change the care they received. This meant the service could not consistently demonstrate that people's needs were reviewed in line with their policy; which could put people at risk of not having their care adapted to meet their changing needs.

People told us staff were competent and knew how to care for them. One person said, "The carers know what they are doing, they are well trained"; and a relative told us, "The nurses are fabulous here, they really are excellent." Staff told us they received "lots of training" and one staff member said, "It's really helped me with my role." In the Provider Information Report (PIR) the registered manager stated that staff had access to specialist training aligned to the needs of residents; for example, end of life training and dementia care. We viewed the training matrix and saw that staff had access to specialist training as well as mandatory training and we could see training was refreshed at the frequency stated in their policy.

The registered manager told us, where possible, they joined pilot schemes initiated by the local health authorities. For example, staff had attended local training on promoting dignity in care for older adults. Staff told us this had been "really useful" and one staff member said, "It changed the way I care for people." One staff member said, "The training made me more aware of the surroundings and how to care for people in communal areas, like how noise and loud voices affect some people". The service now had a dignity champion who promoted good practice amongst the team.

New care staff received an induction which involved mandatory training and working with experienced care staff. Staff then fed-back to the registered manager who then 'signed-off' their induction and probationary period. A new member of the nursing team told us, "I personally feel I have had a good strong induction here. The manager and other nurses offer good support clinically" they went on to say, "Many of the staff are skilled but there are some new ones who need support." Whilst some staff told us they had a 'good induction' we found the induction for care staff was informal and lacking in structure; and we saw no evidence of periodic competency checks or reviews throughout this period. This meant it would be difficult for the registered manager to evidence that staff were progressing through their induction and achieving the standard required to care for people safely and effectively.

The registered manager had said in the PIR, 'staff attend regular supervision sessions to help prevent stress and burn out' and the supervision policy set out the expectation of four to six supervision sessions per year. The supervision matrix we were shown, only covered the previous three months and whilst it showed that most staff had supervision in March 2018, it did not provide evidence of the frequency suggested in their own supervision policy. There were mixed comments from staff regarding the frequency of supervisions, some said they had supervision recently and others could not remember when they last had one. However, they all agreed that supervisions generally took the form of a small group training session on a particular aspect of care. For example the correct fitting of leg bags for people who used a catheter. We saw little evidence of one-to-one supervision meetings where individual staff needs or competencies were discussed. This meant the registered manager was not following their own policy which would make it difficult for them to identify staff who were approaching 'burn-out' and needed support, or to acknowledge individual staff achievements, progress and competence. Therefore, it was not always possible for the registered manager to demonstrate that staff were capable of providing the standard of care people required.

In the PIR the registered manager stated 'We have regular staff meetings and group discussions'. However, staff told us that team meetings were "not very often". One staff member said they had not met all the new staff as there had not been a team meeting "for ages". They went on to say that although information was

shared during handover or directly from the registered manager; this did not replace the bond the team developed when they all met together to discuss things. They said it was also difficult to get a whole team approach to high standards of care and changes in practice if people did not all receive information at the same time and discuss how this would look in practice.

We asked the registered manager to email us copies of the last three team meeting minutes as we did not have time to view these during the inspection visits. The organisations statement of purpose stated there were 64 staff in total, most of these were care or nursing staff, but also included housekeeping, kitchen and maintenance staff. They sent us the minutes for - a general staff meeting dated 27 and 28 January 2018, in which 9 of the 64 staff attended over the two days; a nurses meeting on 15 January 2018, where 4 of the 9 nursing staff attended; a kitchen staff meeting on 20 February 2018, where 3 kitchen staff attended; and an end of life meeting on 14 April 2018, following the death of a resident, where eight care or nursing staff attended. This supported comments from staff that general team meetings were not very frequent and those that did take place were not well attended. This meant there were few opportunities for staff to receive information at the same time and discuss how any changes impacted on their care practice. It also meant there were few opportunities for staff to meet together, share ideas and develop a bond with staff from the wider team, rather than just with the staff they met on their regular shifts. This was not good for staff morale and created opportunities for misinformation or rumours and also impacted on staff relationships.

People were very happy with the variety and quality of the food available at the home. One person said, "The food is brilliant, although I don't have much of an appetite" and another person said, "The food is excellent." At lunch time we observed people in the dining room and saw people enjoyed their food and were able to ask for an alternative or more if they required it. The food was served at a pace that enabled people to enjoy their meal and people were encouraged to eat.

We spoke to some staff who had joined an initiative to improve people's diet and nutrition which resulted in them completing training in how to support people with dysphagia and ensure they had a varied and well balanced diet. Dysphagia is when people have difficulty swallowing solid foods and are risk of choking. Staff showed us how they prepared food for people to the required consistency and used moulds to shape softened food and make it more appealing to people. They told us this had improved people's appetite. We saw some people received softened food in separate portions on their plates which helped show them what they were eating and made the meal look more appealing. We saw people using adapted crockery to enable them to eat independently and assistance offered to those who wanted it. Staff showed us the photo cards they used when assisting people to make their menu choices and explained the different food requirements and preferences of individual people. People were supported to have a healthy and nutritious diet.

Staff told us and we saw information about people's daily care needs was exchanged at shift handovers. Information about people's appointments and planned activities was also recorded in the 'day book'. There was also an admissions book that provided basic information about new admissions and referrals to other residential services. Care staff told us there were good relationships with nursing staff and they felt supported in their roles. Staff told us there was good communication within the team and important information 'travelled fast' throughout the service. They were generally able to tell us about individual people's care needs and of any recent changes to their condition. However, one staff member told us they did not know that a new person was to be admitted to the service on the first day of our inspection. There was also a mixed understanding amongst staff, of a person's status in respect of an infection they had. This demonstrated that the systems in place for information sharing were not always effective in ensuring that all staff had access to up-to-date information regarding people's care needs.

There were strong and positive links with local health services and the local GP told us they had regular weekly visits to the home, where they checked on people's health needs and did medicine reviews where needed. The service had a good relationship with the Community Matron who provided advice and visited the home to discuss people's care. Health practitioners we spoke to before the inspection visit, all said they had good relationships with the service and had no concerns. We saw evidence of referrals for specialist health care in people's care records. For example, for diet and nutritional advice, chiropody and falls prevention; and we saw evidence that care had been adapted following advice from other professionals.

The service is located in a building that was originally a community hospital, parts of which are Grade 2 listed. This means there is little opportunity for adaptation to meet the needs of all the people who live there. There are long corridors and a confusing layout which make it difficult for people to walk around safely and for staff to 'keep an eye' on everyone who needs it. There are steps to the main entrance and the only ramped access is on an alarmed door into the lounge; where the alarm sounds constantly when the door is open to allow people safe access and exit. This is particularly troublesome for people in the lounge when the door is open for a long time; for example, when there are new arrivals or ambulance call outs. Although some rooms had picture explanations – bathrooms and toilets; there was a lack of clear directional signage and no names or picture identification on people's bedrooms. This meant it would be difficult for people with dementia to orientate themselves and may have been a contributing factor to people walking into other people's bedrooms.

However, the building was brightly decorated, well-lit and most of the rooms were light and airy with some having direct access to the gardens. Rooms were personalised and some people had their own furniture in their rooms. There were handrails along the walls of most corridors and lifts to each of the floors. Emergency exits were sign-posted and clear of clutter. There was plenty of garden and outdoor space for people to sit and enjoy the gardens and fresh air; and we saw people enjoying the sunshine during our inspections visits. Staff told us how people enjoyed sitting outside and how it improved their overall wellbeing. There were two lounges and a small dining area which meant people had a choice of areas to sit, relax and entertain their visitors, other than their bedroom.

Good

Is the service caring?

Our findings

People and their relatives were overwhelmingly happy with the care they received. One person said, "Care staff are very good, couldn't get much better, always have a smile on their face… they are a great help when you need it." A relative told us, "I would definitely recommend it, it's marvellous and the staff are wonderful. I couldn't ask for better care." Another relative said, "The housekeeping staff are amazing, so friendly my [family member] loves their visits." When we observed and spoke to staff we could see they were kind and compassionate. One staff member said, "I love working here, I find older people really interesting, they have lived such interesting lives, completely different from ours." Another staff member said; "I like to make sure people receive the care they deserve."

Staff worked a 'key worker' system, which allocated one or two people to each member of care staff. The key worker is the main point of contact for people and their relative's. They were responsible for building a relationship with each person, spending time with them one-to-one and organised their room, belongings and toiletries. Relatives told us this was a positive arrangement and cut down the number of staff they needed to talk to when they wanted to share information. Staff told us there were set times of the day when they were able to sit with people on a one-to-one basis; they told us this helped build relationships and talk to people about their lives. It was also useful when people needed emotional support, as key workers got to know and understand people's emotional needs and triggers; for example on significant anniversaries, events or time of day.

We observed kind and friendly interactions between staff and people. We saw staff gently covering people when they were sleeping in the lounge, offering discreet support and occupying people who were showing signs of distress.

People and their families told us they were involved in planning their care and choosing their daily activities. One relative told us, "We are involved in their care plan; the staff asked us about their personality, likes and dislikes. They keep us informed of any changes and let us know if my [family member] needs anything." We saw evidence in people's care records that family were involved in decisions and relatives told us they were happy with the level of involvement they had. As many people had dementia it was not always possible to evidence how much involvement, if any they had in planning their care. However, there was some evidence of individual involvement when people had capacity to make decisions about their care and daily activities. We also saw evidence of professional advocates involved in people's care planning where this was a condition of the DoLS. Staff demonstrated that they knew people's needs and preferences by their choice of music in the lounge, their choice of food and how they liked to dress.

Initial care plans were developed with people and their families and contained details of their individual needs and preferences. A relative told us, "There was a very detailed pre-assessment before my [family member] came here. The managers nursing knowledge was evident and she involved the family in the assessment and in the care planning." Another relative said, "I can't believe the staff could be as good as me, but they are." Staff told us they offered care equally to all people that was personalised to meet individual and cultural needs.

During our inspection we observed people were cared for with dignity and respect. Staff used people's preferred names and spoke to them individually. We saw staff bend down to eye level and talk to people close to their ears so they could be seen and heard. We saw staff offer discrete care to people who needed personal assistance and we saw staff cover people and rearrange their clothing to protect their dignity. Staff promoted people's independence by offering discrete support or assistance as required and standing back to allow people to do things for themselves where possible. For example, we saw staff offer support in the dining room and stand back if it was declined. We saw some people who looked like they were struggling to eat independently and noticed staff did not offer help; when we asked staff about this they told us that these particular people were fiercely independent and would not accept help, preferring to manage themselves. In such circumstances food was presented in a way to make it easier for people to eat independently; for example, cut into smaller pieces, softened and served in high-sided dishes to prevent spillage. This ensured that people's dignity and independence was promoted.

People at risk of falls were supported to remain independent by the presence of hand rails along the corridors and the availability of equipment to assist them to walk around or move seating positions. Most people who required them, had sensor mats in their rooms or by their chairs in the lounge, to alert staff if they were moving independently. This meant staff could offer the required assistance and reduce the risk of harm from people falling.

Staff were alert to people's needs and pain management. We observed staff enquiring about a person in the lounge who was holding their head; they enquired about pain and offered pain relief. The person declined it and staff stayed with them to comfort them. Staff were aware of people's preferences for male or female staff and told us how important it was to respect this. Relatives told us they could visit at any time and were always made welcome. One relative told us that staff arranged an informal birthday celebration and cake for them when they visited their family member on their birthday. They said this was a lovely gesture and enabled their family member to join in the celebrations as they would have done prior to moving to the home. This demonstrated respect to people and their families and awareness of what is important to them.

Good

Is the service responsive?

Our findings

Staff clearly knew and promoted people's individual choices and preferences. We observed a staff member serving a person's food and they said, "Here you are [name] here is your lunch with gravy on the side just as you like it." We saw another person served grapes and the staff member later said to us, "They have such a sweet tooth and they love grapes. They are also easy for them to eat independently." We saw people were well groomed and presented in clean, coordinating clothes; and saw this matched their personal preferences as stated in their care plan. For example one lady disliked wearing trousers and we saw she wore a dress on both days of inspection.

Staff were able to tell us about people's individual interests, what was important to them and how they liked to spend their day. For example, one person enjoyed reading the daily newspaper and had an interest in science. We saw a poster of the periodic table of elements on their wall, this enabled staff and visitors to engage in conversation with this person regarding their special interest which encouraged them to reminisce about their earlier life and achievements. Another person enjoyed opera music and we heard this played in their room. Staff told us how they escorted people on trips within the 'Peak District'. People enjoyed their 'trips down memory lane' reminiscing about their life and previous visits to local areas of interest. We saw information in care plans about people's religious preferences and staff told us representatives from local churches regularly visited the home to offer services or communion to people. One staff member told us how they held bible reading sessions with a small group of residents who had difficulty reading. People were supported to follow their interests by staff who understood their preferences and life history.

People were encouraged to maintain relationships with family and friends and supported to attend family events and special occasions. For people with distant or no relatives, staff spent more time with them individually, sharing activities or discussing things of interest. We saw the activities worker use a reminiscence box to engage a person in conversation about their memories. They told us later that some people had sensory impairments and had developed difficulty reading books or newspapers. They explained how they had different resources available for people including talking and large print books. We saw one person using a magnifying glass when they were eating which enabled them to eat independently and enjoy their food. We saw that people's need for sensory or specialist equipment was recorded in their care plans and we saw it in use throughout our inspection. This helped ensure people had information about their care and support in ways that they could understand, and the provider demonstrated that they met the Accessible Information Standard. The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

Staff told us that information could be provided in different languages if it was required; but there were no people who currently needed this type of support.

The service used technological aids to alert staff to when people needed assistance. People had call bells in their rooms which they could use to alert staff when they required assistance. Some people wore

'Wanderguard Bracelets' to alert staff when they were approaching the unlocked front door; and some people at risk of falling had sensor mats in their rooms or by their chairs to alert staff if they required assistance to mobilise. Generally these aids were successful in ensuring people received a timely response to their care needs.

The registered manager told us they held resident and family meetings three times each year. External speakers were invited to the meetings from a range of specialist groups to discuss topics of interest. Relatives told us the speakers were "really interesting". A representative of 'Dementia Friends' talked to the group at a previous meeting; this was particularly relevant as many of the people living at Bakewell Cottage had some form of dementia. Relatives also said they had opportunity to feed back to the registered manager and discuss plans and ideas at the meetings.

There was a complaints policy in place and we saw a copy of it on the information board by reception. People and their relatives told us they would have no hesitation in complaining if they were unhappy with any aspect of their care. There had only been two complaints in the last 12 months and both had been processed as per the policy. Changes had been made to laundry management and food options as a result of these complaints.

Relatives were keen to tell us that the registered manager was well informed about their loved ones and was always available to discuss their care. One relative told us, "The manager is on the ball; she knows what my relative has had for dinner and how they are each day. I couldn't ask for better care."

The service had been part of a local initiative aimed at improving end of life care for people and some staff had attended training and workshops to promote 'dying with dignity'. This had been so successful within the service that it had now been rolled out to all staff. Staff told us this had improved their knowledge and understanding of the needs of people and their families when they were approaching the end of their life. One staff member said, "We have brilliant after care for staff when a person dies. The training was a real eye-opener and made you more aware of everyone's needs at end of life." Staff had the knowledge and skills to support people and their families during this period of their lives.

There was also an end of life champion on the staff team whose role was to raise awareness and improve the end of life experience for people and their families. At the last 'resident and relative' meeting in April 2018 the speaker discussed end-of-life care and how to begin the conversation with loved ones about their wishes and preferences. Relatives told us this was really useful and we saw staff discussing this with people after the meeting. We saw people's preferences for their end of life recorded in their care plans, this included a request for particular music when a person was approaching their final moments, funeral arrangements and their right to refuse treatment. The local GP told us they instigated discussion about people's final wishes when they arrived at the home, in order to "get the conversation started". Do not attempt resuscitation (DNAR) were reviewed and signed by the GP and kept in people's care records. They told us it was important to have this conversation with people and their families early on, so people were prepared and understood the decisions that could be made regarding future care, if they had a cardiac arrest.

The registered manager was trained in palliative care and nursing staff said they had anticipatory medicines available for people who were approaching the end of their life. This meant people were pain free and comfortable as they approached the end of their life which led to a dignified death. Relatives told us how sensitive and kind staff were with their loved ones as they approached the end of their life and they also supported families to prepare for the inevitable.

Requires Improvement

Is the service well-led?

Our findings

There were performance management tools and processes in place which could be used to monitor and evidence the quality of the service and the impact on people. For instance, the registered manager collated data each month regarding the number of falls that had occurred during that period. They also audited medicine records monthly, for accuracy and compliance with regulations and guidelines. However, we found these tools were not always used effectively and did not always identify errors or areas for improvement. For example, we found the hand washing audit to be basic and only included four people. This had clearly not impacted on all staff as we saw one staff member repeated coughing into their hands during the lunchtime period and not washing their hands. We also noted that recording of falls did not always feed into risk assessments or lead to changes in care; therefore different options to keep people safe were not always considered. This meant that opportunities for learning and development were often missed which could affect outcomes for people.

Many policies in place to guide staff lacked process or clear direction. They could not be used to hold staff to account or provide evidence of positive outcomes for people. For instance the record keeping policy, did not state that records should be contemporaneous, in clear handwriting, signed and dated. We found evidence in many care records of information written in poor handwriting making it illegible and with no date or signature. This made it difficult for staff to read and understand and could lead to misinformation or errors. Without a clear record keeping policy it was difficult to hold staff to account for this.

In the PIR the registered manager had stated they understood the terms and responsibilities of their registration with CQC. They stated that they routinely sent notifications to CQC and complied with all other requirements of their registration. However, on arrival and during our first day of inspection we noticed the ratings from the last inspection in 2016, were not available or visible for people to see. This is a requirement of the registration process and can lead to a fine if not displayed clearly. We asked the registered manager about this and they told us it had been removed during recent decorating and was waiting to be re-hung in its frame. This remained absent throughout most of the day but it was added to the notice board before we left at the end of the first day.

We found that relevant notifications had not always been sent to us as is required by the terms of registration. The registered manager apologised and advised us they were not aware this was a requirement for this particular instance and would attend to it immediately. We can confirm that notifications have since been received by CQC. We were also concerned to find a potential safeguarding incident had not been reported to us or the local safeguarding authority. The registered manager told us they thought a relative was going to do it. This demonstrated that the registered manager did not fully understand their responsibilities to share information with relevant bodies, regarding known risks to people; and was not consistently following guidelines or regulations.

People and families were consulted during meetings and feedback requested in the annual survey. We reviewed the comments made by people and relatives in the last survey. Some relatives commented about the poor first impression to visitors by the neglected appearance of the front entrance. They suggested

flower pots and a good clean. We noticed action had been taken to address this and we were met with a welcoming display of seasonal flowers around the front entrance during our inspection. However, another point regarding the lack of an accessible ramp at the front entrance had not been addressed nor did we see a written response to this or other suggestions that were made. We viewed resident and relative meeting minutes and noted that people were asked for their views on decoration, menus and activities. Although there were opportunities for people and relatives to feedback to the service and make suggestions, it was not always recorded effectively and there appeared to be no analysis of this information. This demonstrated that the processes and opportunities in place for feedback were not always used effectively; and the registered manager could not always demonstrate how people or relatives were involved in improving the service.

In the PIR the registered manager stated they had regular staff meetings and group discussions. The actual frequency was not specified. We saw minutes of a meeting to discuss a person's end of life care; a nurses meeting; a kitchen staff meeting and a general staff meeting. There was no clear evidence or policy that stated how frequently general staff meetings occurred. Staff told us they were "not very often" and one staff member said, "We could always do with getting together as a staff team more often, it's good for morale." From an assessment of the minutes it appears that staff meetings occur in response to an issue or incident, rather than being planned in advance and giving staff time to prepare. Information sharing amongst the staff team and from the registered manager appeared to be an informal and ad hoc process, with little structure or planning. This meant some staff missed out on opportunities to receive information or discuss concerns or ideas. Few staff we spoke to said they had been consulted about the plans to change the use of a training room into a residents lounge and some made valid points about 'sight lines' and supervising people in this remote room. The systems available to engage with people, relatives and staff were not always used effectively or consistently to enable the views of others to be captured and analysed in a meaningful way.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Governance.

There was a clear vision in the service which staff understood and supported. Staff were focused on providing dignified, personalised care to people, as well as supporting people to maintain their independence and their relationships with family and friends.

The registered manager was considered to be a strong leader and positive influence on staff. One person said, "The manager is fully in charge and has a finger on everything" they went on to say, "The manager's influence spreads throughout this whole place." Relatives were impressed with how much the registered manager and staff knew about their loved ones and what was important to them. Staff had the qualities and skills to do their jobs well and relatives told us the registered manager was very good at picking the right staff. One relative said, "The manager can be a bit fussy, but they only pick the best." Relatives told us the registered manager was knowledgeable and approachable and was always available to discuss their loved ones care. Staff repeatedly told us, "The manager runs a tight ship" but they all said they understood the reasons why. Staff also said, "People are the reason we all work here, we only want the best for them."

The registered manager told us they or their deputy attended local provider or sector meetings in order to keep up with new practice, guidelines and expectations from commissioners. The service participated in local initiatives where appropriate and this had led to improved practice within the service and positive outcomes for people. For example, the service had twice been awarded the Derbyshire End of Life Quality Award which they worked hard to achieve and were very proud of. They were currently working towards their second 'dignity' award and staff told us this had improved their understanding of people's needs and

their practice. There were three student nurse mentors in the service and the registered manager was keen to increase the number of student nurses they offered placements to. They explained how important it was for student nurses to be exposed to caring for older people and end of life care during their training, as this was an important part of our health service. The registered manager was also part of an initiative to reduce the number of unnecessary hospital admissions for older people. They told us how most older people preferred to be treated at the home by people who knew them for as long as possible, rather than be admitted to a hospital where they could become isolated and distressed. They also said Bakewell Cottage was the preferred place for people to end their life. This demonstrated the service kept up-to-date with new initiatives and used these experiences to improve outcomes for people.

There were productive partnerships with other healthcare agencies in the area and the staff worked with specialist health care professionals to offer coordinated care to people. There were weekly GP visits, six weekly chiropodist visits, fortnightly visits from the hairdresser and many more planned activities arranged with people in the local community or visits from specialist services. This ensured people accessed the care they needed and maintained contact with the local community which was important for their identity, independence and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had not consistently followed the principles of the MCA. Therefore, decisions regarding people's care were made without due authorisation or full consideration of people's rights and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always share information regarding known risks to people, with relevant bodies. This included safeguarding referrals and notifications to CQC. Risk assessments were not always in place or not consistently followed. Medicines were not consistently well managed. Storage of medicines and application of medicine 'patches' was not effectively monitored and there were few 'as required' PRN medicine protocols in place. Staff were not always deployed effectively; and were not always able to maintain the frequency of checks that people needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance and quality assurance systems

were not used effectively to evidence performance, quality of care, or outcomes for people.

It was not clear how the views of others influenced service development.

Notifications had not always been sent in a timely way.

The staff supervision and team meeting process was not well structured or robust enough, to effectively develop staff and improve the quality of the service.