The Adelaide Lodge Care Home Limited Liability Partnership

Adelaide Lodge Care Home

Inspection report

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Date of inspection visit: 8 and 9 December 2015
Date of publication: 26/02/2016

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 8 and 9 December 2015. The first day of the inspection was unannounced.

Adelaide Lodge is registered to provide accommodation for 48 people who require personal care. Some people using the service are living with dementia and other mental and physical health issues. At the time of the inspection there were thirty eight people living at the service.

We last inspected this service on 19 February 2014 and found that the service was meeting the requirements of the regulations we inspected at that time.

The registered manager had left the service in October 2015. A new manager had been appointed and started working at the service on 7 December 2015. They were in the process of completing a CQC registered manager's application. Following the inspection an application was to register with the CQC was submitted, which is being processed. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.'

Not all aspects of the recruitment process were robust. Recruitment checks on prospective staff did not include information about their full employment history to ensure they were suitable to work with people.

People received their oral medicines as prescribed. However, not all aspects of the management of medicines were safe, in particular the use of prescribed creams was poorly documented.

Staff did not comply with the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. This was not being done and may have led to staff making unauthorised decisions on other people's behalf.

DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The staff were not fully informed about DoLS protection; they had not taken the required steps to gain the legal authority to subject people to continuous supervision and control, including preventing them from leaving.

There were a range of audits and systems in place to enable the provider to monitor the quality of the service provided. However, the quality assurance system was not always effective because issues identified at the inspection had not been recognised during the auditing and monitoring process.

The senior management team had recognised improvements could be made at the service to benefit people living with dementia. People living with dementia would benefit from activities based on current good practice guidance for dementia care.

People said they felt safe living at the service because they knew staff were available when needed. People and their relatives said staff were caring, kind, friendly and respectful. Comments included, "…I want to say how kind people (staff) are…" and "I like it as it is. It's very good I have got no complaints at all. They are very obliging if you want any help they give you what you want."

The service ensured people were protected from abuse. Staffing levels were supportive of people's needs. The provider used a 'dependency' tool to calculate staffing levels to ensure people's needs were met. Risks to people's health and safety had been identified and actions had been taken to reduce the risk of harm. Accident and incidents had been reported appropriately and regular analysis of accidents and incidents was used to identify any trends or changes that could be made to prevent recurrence.

People were supported to eat and drink enough and maintain a balanced diet. Staff, including the cook were knowledgeable about people's individual nutritional needs. People had access to healthcare professionals to meet their health needs. Feedback from professionals showed the service worked in partnership with them for the benefit of people using the service.

Systems were in place to ensure the service was clean and that people were protected from

acquired infections. The service was clean, fresh and entirely odour-free throughout. The premises were well maintained and in good decorative order. However, the environment was not enabling for people living with dementia as physical features such as signage and colour schemes did not support their independence or help them with 'way-finding'.

Staff had opportunities for regular training to enhance their skills and knowledge of working with people at the service. Staff said they were well supported by the management team.

Needs assessments and care plans were comprehensive in most respects, and regularly reviewed to ensure staff had the information needed to deliver safe care. People said the home took care to understand and respond to their needs and personal preferences. One person described responsive, observant, inclusive and flexible practice in how and when they received person care. A relative expressed confidence in the service and talked about its individual approach to meeting people's needs.

People knew who to speak with should they have any concerns. The senior management team confirmed no complaints had been received by the service in the past 12 months.

Summary of findings

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

Some aspects of the service were not safe.

Appropriate pre-employment checks had not been completed on all staff prior to them starting work at the home.

Appropriate arrangements were not in place for the safe management of all medicines.

There were systems in place to make sure people were protected from abuse and avoidable harm. Risks to individuals had been considered and actions were in place to reduce identified risk. There were enough staff on duty to ensure people's care needs were met.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Where people did not have the capacity to consent, the provider had not acted in accordance with the legislation and guidance. The principles of the Mental Capacity Act 2005 were not always followed when people did not have capacity to make decisions. People who may have been deprived of their liberty had not always been assessed.

The physical environment of the service had not been adapted to meet the particular needs of people living with dementia and maximise their independence.

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

People had access to relevant healthcare professionals, where required.

People were offered a varied and nutritious diet and they were supported to eat and drink to ensure they maintained good health.

Is the service caring?

Good

The service was caring.

Staff had developed positive, caring relationships with people who lived at the service. People were supported to express their views so they were involved in making decisions about their day to day care and support.

For the most part people had their privacy and dignity respected by staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

The provision of activities available for people was not always suitable to stimulate and engage them.

Summary of findings

The daily personal care delivered to people was personalised and responsive to their needs. Care plans had been written with the involvement of some people and their families.

The service had a complaints procedure and people were aware of how to raise concerns. People were confident the provider would respond positively to any complaints or concerns.

Is the service well-led?

Requires improvement

The service was not always well led.

The quality monitoring arrangements were not fully effective. This was because they had not identified the concerns and breaches of regulations we identified at the inspection.

Systems for obtaining the views of people who used the service were in place and people's suggestions were acted upon.

The staff worked in partnership with other health and social care professionals in managing people's mental and physical health.

Adelaide Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 8 and 9 December 2015. The first day of the inspection was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service.

Before our inspection we reviewed the information we held about the service, which included the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

Some people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to give us an insight into people's experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on their experiences. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke with 16 people using the service; five relatives of people using the service; four health and social care professionals; and 11 members of staff including the senior management team (the provider partner; the new manager; head of care; training manager; and deputy manager) and care staff and ancillary staff.

We reviewed the care records of six people and a range of other documents, including medication records, three staff recruitment files and staff training records, and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

Recruitment checks on prospective staff did not include information about their full employment history, nor were gaps in employment history explained within the recruitment records. Discussing gaps in employment history would ensure that people were protected from staff who may not be fit to work with vulnerable people. Other checks were present and had been obtained prior to new staff starting work at the service. For example, application forms, proof of identity, two references from recent employers and a satisfactory Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they received their oral medicines as prescribed; however, not all aspects of the management of medicines were safe. Staff assisted several people with the application of prescribed creams. However, there were not always clear directions about when the creams should be used or where to apply the creams. Records did not confirm creams had been used as prescribed. Two senior members of care agreed there were significant gaps in the records. This meant the prescriber of the medicine could not be confident creams were used as intended. We found creams, which had a limited efficacy once opened, had not been dated to ensure they were not used past their 'best before date'. There was an inaccurate record of the stock held for one medicine which required additional safe storage. This was corrected by senior care staff once pointed out to them during the inspection. Gaps in medicine records had been identified during regular medicines audits and this had been discussed with staff with reminders given to ensure records were accurate. During the inspection senior care staff implemented a weekly audit of the use of creams to ensure records of their use was accurate. **We recommend the service follows the NICE National Institute for Health and Care Excellence Guideline, Managing Medicines in Care Homes Published 14 March 2014.**

Other aspects of medicines management were safe. Medicines were stored safely and at the temperature recommended by the manufacturer. There were effective systems in place for the receipt, administration and disposal of medicines. Staff responsible for the management of medicines, including administration, had received training to help ensure safe practice. We observed staff assisting people to take their medicines; this was done is a sensitive way and at each person's pace. One person was telling their relatives that they needed some medicine as they were in pain. Staff explained to the person when they had last had medicine and when it was next due.

People said they felt safe living at service. When asked what made them feel safe, one person said, "The staff are very kind and they come running when needed….I wouldn't stay if not…it is first class here." Other comments included, "I would recommend this place…I have no worries or concerns…" Relatives confirmed they felt their family member was safe. Comments included, "I really don't have any concerns about safety…" and "The staff are very good with people…I have not heard a cross word." Health and social care professionals confirmed they had no concerns about people's safety. One said, "I have no concerns at all. They have a very professional approach"; another said, "I have been 100% impressed with what they do…"

Staff received safeguarding training to help them recognise possible abuse or neglect. Staff had an understanding and knowledge of the different types of abuse and understood whistleblowing procedures and how to report unsafe practice. Whistleblowing is when a worker reports suspected wrongdoing at work. The service had policies and procedures in place for staff to follow if they witnessed or suspected abuse. Staff said they would not hesitate to report any concerns and they were confident that senior managers within the service would act on any concerns. One member of staff said, "Any abusive behaviour would not be tolerated here…" A person living at the service said, "There is no nastiness from the care staff. I am quite happy… nobody would do me any harm or steal anything"; The records we hold about this service showed that there had been no safeguarding incidents in the past 12 months.

People said they felt that their possessions were safe in the home. Asked about their belongings and ability to lock their bedroom one person said, "I've got a key for that drawer (pointing) and I can lock the main door."

Staffing levels were supportive of people's needs. Staff spent time with people chatting or assisting them with activities such as helping them with their post and reading a paper, in addition to carrying out care tasks. People using the service said they felt there were enough staff on duty

Requires improvement

Is the service safe?

and that staff were available when they needed them. Comments included, "They (staff) respond very quickly to the call bell" and "I only ring once most of the time, sometimes twice but rarely. It is very good here". Everyone we spoke with, including relatives, said they felt staffing levels were sufficient. A review of the staff rotas from 30 November 2015 showed the preferred staffing numbers had been consistently maintained.

The provider used a 'dependency' tool to calculate staffing levels to ensure people's needs were met. The tool measured the dependency of people according to their care needs to inform the numbers of staff available to meet those needs. This was used regularly to determine staffing levels. Sufficient numbers of ancillary staff were also employed, such as housekeeping and kitchen staff, and maintenance staff to undertake cleaning, laundry and the preparation of meals. This meant the provider had formally assessed whether staffing levels were meeting people's needs. Where sickness or holiday cover was needed, existing staff offered to cover extra shifts. Staff confirmed they were happy to help and this meant they did not have to rely on agency staff.

Risks to people's health and safety had been identified. Care records contained risk assessments, which identified individual risks and included actions for staff to take to reduce the risk of harm. For example, the support individual's required to prevent pressure damage. Where people were at risk, pressure relieving equipment was in place and regular reviews of people's skin were undertaken. Where people were at risk of falls, risk assessments identified equipment to be used. Some people were at risk regarding nutrition and hydration and risk assessments and care plans addressed these risks along with clear instructions for staff to follow to reduce the risk. Risk assessments were regularly reviewed and up-dated with additional actions where necessary. Staff said they were made aware of the risks for each person and how these should be managed. Staff said they had time to look at people's care records, and people's needs and risks were discussed at the daily handovers to ensure staff were up-dated.

Staff were aware of what they would do in the event of an emergency, such as if a person fell or if there was a fire. Care records contained a personal emergency evacuation plan (PEEP) which showed what assistance individuals' would need in the event of an emergency. Some contained more detail than others about the individual's ability. The new manager said they had a more detailed format for assessing people's needs in the event they should need to evacuate the building. They were planning to review all emergency plans over the coming weeks.

Accident and incidents had been reported appropriately and reports included details of when and where the accident occurred, whether any injuries had been sustained and if any first aid or medical treatment was required. An analysis of accidents and incidents was used to identify any trends or changes that could be made to prevent recurrence and reduce the risk of possible harm.

Systems were in place to ensure the service was clean and that people were protected from acquired infections. Sufficient housekeeping staff were employed and we found the home was clean, fresh and entirely odour-free throughout. We were told that the home places significant emphasis on attention to cleanliness, for both infection and odour control purposes. Staff had been very successful in this work. People using the service, relatives and professionals said the service was always clean with no unpleasant odours. Staff confirmed there were always sufficient supplies of protective equipment such as gloves and aprons. Bathrooms and toilets contained liquid soap and paper towels to promote hand hygiene. The laundry was well organised with suitable equipment available and systems in place to manage soiled laundry.

The premises were well maintained and in good decorative order. Environmental risks to people had been addressed. For example, radiators were covered to reduce the risk of burns and hot water was maintained at a temperature which did not pose a risk of scalding in those checked. A contractor was testing smoke alarms during the inspection. They said, "I have been coming here for 20 years…the facilities are excellent. There has been a lot spent on infrastructure and the upkeep for example the fire alarms in the boiler room are up to date...." The contractor added "He (the provider) doesn't hold back on spending money. It shows that the owner cares". A call bell monitoring system was in place, which showed the response time on a screen to enable the provider to monitor response times. This equipment was described as "state of the art."

The PIR showed that water was monitored for the risk of Legionella. Fire checks and drills were carried regularly.

Requires improvement

Is the service safe?

Five year electrical testing was carried out as well as 'Pat Testing' of electrical equipment to ensure their safety. There were maintenance and service contracts in place, for example the lift was serviced and tested every six months.

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.

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known. For example, how they wanted to spend their time and whether they wanted help with personal care. There were consent forms completed in some records but not all. They related to 'care and treatment' and so were not specific about what people were consenting to. Nor was it clear who had been involved or whether staff had enabled people to make informed consent when completing the forms.

Relatives (and others) can only give consent where they have the legal authority to do so, for example through a valid Lasting Power of Attorney or appointment as a Court of Protection 'deputy'. Properly taken and recorded 'best interests' decisions or other valid processes are required in other circumstances. However, there was no evidence that best interest processes had been followed at the service.

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's capacity to make specific decisions had not been assessed although there were assessment forms for this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

There were people who were not free to leave and/or who were under constant supervision. For example, the home had a keypad lock on the front door, and each bedroom door was fitted with a switchable device able to alert staff when the door was opened. Staff said their purpose was to prevent people living with significant dementia from leaving their rooms or the home unnoticed. Whilst this was done with people's safety as the priority it showed that there were restrictions on their liberty. The use of the devices was mentioned in risk assessments and in care plans. However, there was no evidence of whether those people had capacity to consent to the use of the equipment and no best interest decisions were made relating to the use of this equipment. The deputy manager and care director confirmed best interest decisions were not taking place in relation to the use of these devices.

The management team said that none of the people living at the service currently had a DoLS in place; however an application in respect of one person had been submitted to the local authority. We found the management team had not identified other people within the service who may have required a DoLS authorisation in line with criteria arising from the supreme court judgement in 2014. Senior staff confirmed people who used the service would be assessed to decide if any DoLS applications were required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Documents in relation to people's wishes about end of life care and cardio-pulmonary resuscitation had been completed by health service staff. These were called Treatment Escalation Plan ('TEP') and they describe whether a person has capacity to make decisions about end of life care. Some had been completed in a valid way, but not all. The registered provider had not engaged with relevant GPs to resolve the invalidly completed documents.

Several people living at the service said they liked the environment and the surrounding gardens. One person said, "It is very comfortable here…I particularly like the garden…" Another person said, "You can see, the place is bright and clean and the furniture is comfortable….most of it is quite new…" However, the home's physical environment had not been adapted to meet the particular needs of people living with dementia. Corridors and doors were decorated in white and magnolia throughout, with the same or similar floor coverings, and the same pictures in some corridors. This meant that people living with dementia were less able to orientate themselves independently. For example, by the use of different colours in different parts of the building, and to identify such things as toilet, bathroom, lounge and bedroom doors. At one point we helped someone find the toilet. They were relieved once they saw the pictures on the door but they were not able to locate the toilet independently.

A mental health professional described parts of the communal areas as "…a bit institutional…" and felt people living with dementia would benefit from a more stimulating and enabling environment. The 'head of care' said they accepted people would benefit from an improved and softened environment. **We recommend that the service seek advice and guidance on environmental adaptations for people living with dementia.** There are a variety of freely available sources of advice in relation to the use of colour and other features to promote familiarity and orientation.

The service had numerous helpful adaptations to promote the care and well-being of people with physical disabilities and restricted movement. For example, it had wide corridors, large communal areas, a lift to the upper floor, and disabled access toilets, bathrooms and gardens.

People using the service, relatives and professionals expressed their confidence in the staff's knowledge, skills and ability; they said they felt staff were well trained to meet people's needs. For example, a person using the service said, "Oh the staff are always having training…" One relative said, "Staff understand Mum…they are all very good…" One health professional said staff would benefit from additional dementia care training to ensure their approach was person centred. Records showed that 24 of the 38 staff employed had completed dementia care training. The provider and senior management team described the future training planned for all staff, which was in line with nationally recognised good practice for dementia care.

Staff were very positive about the training and support offered to them. They received training in relation to aspects of health and safety, such as safe moving and handling; safeguarding; infection control; health and safety and fire safety. More specialised training had been completed by some staff, for example understanding dementia, end of life care, diabetes care and other specific healthcare conditions. A training co-ordinator had been appointed and was in the process of reviewing staff training and developing a new training programme.

50 % of the staff working at the service had obtained a nationally recognised qualification in health and social care. New staff followed the Skills for Care 'Care certificate' (a new nationally recognised tool for staff induction) to help build their skills and competence when they first starting work at the service. New staff also 'shadowed' experienced staff to help them become familiar with people's needs and help them to work safely with people.

Staff supervision had taken place at regular intervals and staff confirmed they felt well supported through this process. This provided staff with an opportunity to discuss their work and training needs and hear feedback from their line manager about their performance.

Care records showed that healthcare professionals were contacted as required to support and advise staff about people's health care needs. These included GPs, community nurses, speech and language therapists, physiotherapists and mental health specialists. People using the service confirmed they could see their GP when needed. Comments included, "Yes they have fixed the doctor for me quickly in the night" and "I can have the doctor if I ask or if they (staff) spy anything they get on with it". A relative said her mother was waiting for a hearing aid and that staff "were on the case". All health and social care professionals said the service contacted them to make appropriate referral when necessary and that their

Is the service effective?

recommendations were followed by staff. One said, "We work very well with the team…overall the service is fabulous…" Another professional said, "They contact us regularly when they know people would benefit from our service…"

People were complimentary about the meals. Comments included, "We have a new cook, and she is very good she cooks using sauces. There is a menu on the table - so can make a choice at that time…"; "I am quite satisfied with the food…it is very tasty…" and "…I am a fussy eater but I enjoy it."

People were offered a varied and nutritious diet and they were supported to eat and drink to ensure they maintained good health. One person was sleeping when lunchtime started. Staff tried to rouse the person gently. When unsuccessful the person's food was saved for later in the afternoon when they were more alert and able to enjoy their meal. At mealtimes, staff supported people in an unrushed, discrete and thoughtful way. Staff engaged in conversation with people, which made the mealtime sociable. They encouraged people with their meal and asked if they had eaten enough or would like more. One person with a visual impairment said, "They (staff) put it (food) on my bed table and they help me to find it." People were supported to be independent at mealtimes, with some people using special equipment such as plate guards and cutlery which enabled them to manage with little support.

There was a choice of the main meal, which was served at lunchtime. A trolley was brought to each table at lunchtime offering a choice of several appetising looking puddings.

There was also a choice of suppertime menu. Food options and menus' were discussed during 'residents meetings'. A recent survey had also asked people about food and menu choices. One person explained that people living at the service had expressed a wish to have duck on the menu. They said, "within a week ducks were on the menu…"

People were regularly offered a choice of drinks throughout the day; including tea, coffee, and squashes. In one of the lounges there were two jugs of water and juice underneath the TV but these were not touched one morning although people were offered plenty of tea and coffee. Fresh fruit was offered as a snack in the afternoons and people said they enjoyed the fruit and cakes provided for afternoon tea.

Staff were aware of those people who were at risk nutritionally and they were observant of people's dietary intake. Food and fluid intake was recorded, although some records were more detailed than others in regards to the amounts people had eaten. Where people had been identified at risk of weight loss, this had been discussed with their GP and where needed people received additional calories in their meals or supplement drinks were used. A relative explained staff had noticed their family member was losing weight; they had been invited to a care planning review to discuss the actions to help prevent further weight loss. The cook was aware of people's dietary needs and preferences. They ensured pureed food was served separately, which looked attractive and helped people to distinguish between tastes. Staff were aware of which people required the use of a thickening agent for their drinks and they ensured these people were supported to reduce the risk of choking.

Good

Is the service caring?

Our findings

During the initial meeting with the manager and the deputy, we asked whether there was anything they were particularly proud of that they would like to bring to our attention. The manager said they thought staff were particularly good at caring for people, and that this could be seen in the day to day running of the home, relationships with families, a feeling of calm, a nice environment, and feedback from families.

People spoke positively about staff's kind and caring approach and the quality of care and attention they received. Comments included, "It is very good. I have been here 4 years. I want to say how kind people are"; "The staff, no matter what their nationality, are wonderful…"; "They are very obliging if you want any help they give you what you want" and "They are very kind and look after me well in all aspects, nothing is too much trouble for the helpers. They are all nationalities but all have the same attitude." Relatives were equally positive about the overall standard of care and staff attitude. Comments included, "My (relative) is very well looked after and is so much happier because she got over the stress and the loneliness when living in her own home"; "The care is generally very good" and "They seem to be very caring".

The vast majority of interactions we observed showed staff were kind and caring in their approach to people and they spoke with them respectfully, with the exception of one member of staff. Although well meaning, aiming to support people's safety, the tone and manner used on two occasions did not up-hold people's dignity or self-esteem. We discussed this with the management team in order that they could offer additional training or support.

Interactions and staff approach in the communal areas confirmed a relaxed atmosphere with continuous conversation between individuals and small groups. Staff dropped by frequently and monitored people's well-being diligently, chatting with people as they did so. When staff assisted people to transfer from wheelchairs to chairs, they took care to ensure they were gentle and transfers were unhurried. Staff explained what was happening and what they were about to do at all times. Staff respected people's privacy and they were discreet when offering assistance with personal care. One person said, "I am quite happy…they are very helpful and they come and look after me alright. They never hurt me (when receiving personal care.)"

A high proportion of the people using the service were living with dementia. Reviews of care records showed some people had related histories of behaviours that could challenge that had diminished after they moved in. One visitor said their relative had a history of very troubled behaviour before moving to the home, but they were now much happier. The calm atmosphere at the service was likely to be helping people feel more confident and settled.

Staff took time to listen to people, to get to know them and they responded to their questions and requests in a timely and friendly way, even if the person repeated the question several time. One person explained they had enjoyed listening to racing prior to living at the service. They said staff had made sure they could continue to enjoy this. They said, "I had headphones before I came here and they fixed it for me to have them here." Another person said, "It is a very pleasant time... I thoroughly enjoy it this new life". Staff had noticed one person enjoyed 'lounging' in their chair but they recognised the person would be more comfortable on a small sofa. A small sofa was provided and we saw this person relaxing, looking very comfortable and at home.

Staff took time to make sure people's appearance was as they would like; women had co-ordinated clothing and jewellery and men were smart and clean shaven (if that was their choice). Two people said they enjoyed being 'pampered', having their hair and nails done regularly. They said how important that was. Another person said, "One of the girls paints my nails. I ask for the hairdresser." All of the people we met with were appropriately dressed. When staff noticed one person had spilt food on their jumper, they gently encouraged the person and help them to change, which promoted their dignity. Relatives confirmed people's personal care and appearance was well attended to. One said, "(My relative) is always clean and tidy"; another commented, "Clothes are always nice and clean, Mum always looks comfortable…"

Relatives said good relationships had been achieved and maintained with them by the staff team and managers. They said they could and did visit at any time, and that they always received a warm welcome. Comments included,

Good

Is the service caring?

"We can visit without restriction…I always get a warm greeting…"; "They are very welcoming and bring a tray for both of us" and "we are always greeted and get a cup of tea".

People were encouraged to bring familiar items from home to personalise their rooms. People's bedrooms were personalised with photographs and items of importance and interest to the individual. One person explained how important it was to them to have particular items with them. They said, "I was able to bring some small pieces of furniture, my books and photos…it makes it feel more like home…" Another said, "It is very good here. My bedroom is very nice."

People using the service and their relatives were able to express their views and their views and suggestions influenced the service. There were formal 'residents' meetings, and occasional 'relatives' meetings. These provided an opportunity for the service to hear feedback from people to discuss ideas and share information about any changes to the service. People using the service and their relatives were able to express their views and their views and suggestions influenced the service. For example, one person explained their relative rang daily and they did not like to use a mobile phone. They said, "I moaned about the mobile to the owner. He responded to my request for a landline saying 'blow the expense it is your home now…'" A relative said the provider had taken immediate action following a suggestion from them and another relative said when they mentioned their family member would benefit from a draft excluder it was provided.

People had access to information about the services offered at the home, activities, and the complaints and fire safety procedure. One person said, "I have no worries...they are kind and if I have any questions they are only too willing to assist me by explaining things." This meant people had access to information in order to make decisions about their care and daily life.

Requires improvement

Is the service responsive?

Our findings

The senior management team had recognised improvements could be made at the service to benefit people living with dementia. The management team said the previous manager had been attending development meetings designed to support preparing the home for 'Butterfly' status. This is a scheme of dementia care standards designed by an organisation called 'Dementia Care Matters'. The scheme's quality checklist had yet to be applied to the service. The 'butterfly' project provides the opportunity to implement a holistic approach to improving the culture of care. The projectprovides a focus on improving the lived experience for people living with a dementia through a mix of the methods, including enabling and stimulating environments and meaningful occupation and activities.

The service employed two part time activity coordinators for the purpose of arranging and planning activities. We received mixed feedback about the activities available for people using the service. Comments included, "I am bored to tears…I am not one for sitting…"; "Although we do have outings (picnics; a visit to the Zoo and a Safari park in the Summer), it would be nice to get out more often…" and "Not a lot goes on some days….it depends on the day…" One person said, "They seem to stick to things they (the activity co-ordinators) enjoy rather than what other people enjoy... There are lots of quizzes and the person in charge of activities sometimes only involves a small number of people." One health professional said, "I am not sure the activities programme is always carried out…" They felt activities offered did not always meet the needs of people with dementia.

People who did not want to participate with or who were unable to take part in group activities had one to one time with the activity co-ordinator. However these sessions were brief and infrequent. For example, the activities records for two people from June 2015 to November 2015 showed one person had received five one to one sessions in this time. The records for this person also showed on three of these occasions they were either sleeping or not responsive. The records for a second person stated they had been offered five one to one sessions in five months but on three of these occasions they were asleep. There was no evidence that these people had been offered any other activity or meaningful social opportunities to minimise isolation.

The activities co-ordinator had worked with some people looking at their past life. They had discovered two people's past interests and working history and had created posters about their experiences. Three people made positive comments about the activities offered. These included, "There are things to do. I am quite happy"; "There is a music man and he always sings my song" and "I enjoyed watching the birds fly" when the bird sanctuary visited the service.

Other recent activities included, reminiscence and exercise sessions; live music from external entertainers; board games; jigsaws, bingo and pampering sessions. Several events, such as an inter-home quiz; open day and fundraising events had taken place earlier in the year, which people said they had enjoyed. During the inspection we observed the activities co-ordinator interacted with people in a caring and compassionate way. Records from the last 'residents' meeting' held in September 2015 showed the 14 people attending the meeting were happy with the activities offered. However, people living with dementia would benefit from activities based on current good practice guidance for dementia care. For example, the use of sensory items, rummage boxes and comfort items, which help to prompt meaningful conversations, social interactions and recollections for people. **We recommend that the service seek advice and guidance on developing activities for people living with dementia.**

People confirmed that before moving to the service, they had been visited at home, or in hospital by staff to talk about the services offered and their care needs. Some people had visited the service before making the decision to move in. One person said they had heard "…only good reports about the service." They added, "We visited and I was quite impressed…they made me feel very welcome here…"

Needs assessments and care plans were comprehensive in most respects, and regularly reviewed. Care plans are a tool used to inform and direct staff about people's health and social care needs. Senior care staff were responsible for monitoring blood sugar levels for three people. However, there was little detail about how to manage the effects of diabetes in care plans. For example, what an acceptable blood sugar level would be for an individual and what to do should levels fall or rise. A senior member of staff said they would speak with GPs as soon as possible and ensure

Is the service responsive?

these details were included in care plans. Other risks associated with care were recognised and appropriate plans made to manage them. Some care records contained completed 'Life History' documents, which recorded information about the person's life. This helped staff to engage with them about past experiences and interests.

Some people were able to confirm that they or their families, where appropriate, had been involved in making decisions and planning their care. One person said they felt "engaged in decisions" when their care was planned. Other people could not remember which in some cases may be due to memory difficulties. Evidence of people's input included details about the person's life and past experiences. One relative expressed surprise that they had not seen any or be involved in their relative's assessments and planning. However two other relatives confirmed they had been involved in supporting their family member when planning their care. This showed there was an inconsistent approach to involving people and their relatives in planning their care.

People said staff took care to understand and respond to their needs and personal preferences. One relative spoke warmly about their family member's admission to the home in very difficult circumstances. They said the staff had been very caring, flexible and understanding. They added staff had taken great care to understand their relative's needs, and followed a highly individual and sensitive approach to care. They said that more recently the staff's strong focus on involvement and independence had enabled their relative to recover a significant degree of mobility and independence after a stroke. Another relative also expressed confidence in the service and talked about its individual approach to meeting people's needs. They and their family member had spent a long time choosing the home, and felt that their decision had turned out to be the right one. The person using the service said staff treated them as an adult, and that they felt in control of their life despite considerable personal care-related needs. They described responsive, observant, inclusive and flexible practice in how and when they received person care.

One health professional explained how the service was providing 'person centre care'. They described the support and encouragement given to one person to enable them to regain their independence. They added, "They (staff) were fantastic and supported one person's discharge…" However one relative observed the service as "institutional...geared around giving them care...not letting residents do things themselves." They felt people were managed and gave the example of everyone being "toileted before lunch". Staff explained people could request assistance at any time to suit them and confirmed people were also 'offered' assistance to visit the toilet prior to mealtimes.

People confirmed they had not needed to make a complaint but that they would not hesitate to speak with staff if they had any concerns. Comments included, "You can speak with the staff. They are lovely and listen to me…"; "I have none at all (complaints)…I could speak with any staff. They are very capable…" and "I would speak with the boss (the provider)…he would sort things out if needed…but I have no concerns or worries." There was a clear complaints procedure in place, which was displayed in the reception area. The PIR and discussion with the senior management team confirmed no complaints had been received by the service in the past 12 months. The management team explained they liked to deal with any concerns immediately to prevent any problems from escalating.

Requires improvement

Is the service well-led?

Our findings

There were a range of audits and systems in place to enable the provider to monitor the quality of the service provided. Regular quality monitoring visits were carried out by the provider which focused on staffing issues, the premises, and complaints and concerns. From the audits we could see that action had been taken in relation to these issues, for example maintenance issues had been addressed. However, our findings at this inspection showed the quality assurance system was not always effective because issues identified at the time of our inspection had not been recognised during the auditing and monitoring process. For example the shortfalls surrounding medicines management, staff recruitment practices, consent, the implementation of the MCA and the lack of person centred activities.

People and their relatives, and health and social care professionals said the home was well run and senior staff were always visible at the service. It was evident through our observations the management and staff team had a good knowledge of and relationship with the people using the service. We saw people engaging with the provider who knew them well. People described a culture where they could confidently make suggestions or request different things. Health and social care professionals described an openness and willingness from the service to work with them and carry out their recommendations.

The home's management had undertaken recent stakeholder survey work in respect of the quality of service offered. Residents, relatives, staff and external professionals had all been asked to complete survey forms. The questions covered most aspects of life and care at the home. Responses had been coded, analysed, and helpfully presented in 'infographic' charts as well as in narrative and numbers. Most responses were highly complementary, with some areas for improvement. It was noteworthy that respondents were asked to identify themselves and that staff had both done so and drawn attention to areas for improvement. The tone in their responses was honest and positive. Staff to confirmed that the home's management welcomed their feedback, and involved them in discussions about improvement. People using the service and their relatives said that their suggestions and questions were encouraged and welcomed. This demonstrated the service routinely listened to people and staff and learned from people's experiences. Improvement planning was not always specific and time-scaled. **We recommend that good practice advice in respect of setting and achieving improvement plans is reviewed.**

Regular staff meetings were held at the service, which gave staff an opportunity to share their opinions and feedback on the service. Minutes showed a variety of issues were discussed and staff given feedback about their expected approach.

The management team undertook regular analysis of accidents and incidents to identify any trends or patterns. This demonstrated the service maintained accident and incident records and carried out adequate monitoring to reduce the risks of them happening again.

There were systems in place for managing health and safety at the home. For example regular fire safety checks and tests had been carried out. Equipment, such as hoists, and heating and electrical systems had been serviced and maintained.

In September 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored a rating of 4, confirming good standards and record keeping in relation to food hygiene had been maintained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 **Regulation 11 HSCA (RA) Regulations 2014** **Need for consent** How the regulation was not being met: The provider did not have suitable arrangements in place to obtain and act in accordance with the consent of people who used the service in relation to the care and treatment provided for them.

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014** **Safeguarding service users from abuse and improper treatment** How the regulation was not being met: The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. We had concerns some people may be deprived of their liberty without authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 HSCA (RA) Regulations 2014**

This section is primarily information for the provider

Action we have told the provider to take

Fit and proper persons employed

How the regulation was not being met:

The provider had not ensured that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity.