Dorrington House

Dorrington House (Dereham)

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

Summary of findings

Overall summary

This inspection took place on 26 and 28 September 2017 was unannounced. Dorrington House (Dereham) provides accommodation and care for up to 45 people. The registered manager and provider told us that they specialised in dementia care. At the time of the inspection there were 41 people living in the home, 36 who were living with dementia.

The service had a registered manager. 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.

At our last inspection of this home in October 2015 we awarded it an overall rating of Good. At this inspection we found that not all aspects of the quality of care provided was good. Therefore, our judgement is that the overall rating for the home is now Requires Improvement. There were three breaches of regulations. These were in respect of regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risks to people's safety had not been adequately assessed or managed. Some prescribed creams were not secure within people's rooms and it had not been assessed whether this was safe. Staff were not always vigilant to particular risks such as falls and therefore, did not take appropriate action to reduce the risk of harm to people.

Consent had not always been obtained in line with the Mental Capacity Act 2005. This Act states that certain steps need to be followed when a person is unable to consent to their care and treatment. There was a lack of evidence to show that all the required steps had been followed as are required.

Some of the systems the provider had in place to monitor the quality of care provided were not effective. This included ensuring people received their prescribed creams correctly and the management of some risks to the premises. Although staff had received training in a number of different subjects, the provider did not have an effective system in place to ensure staff understood this training and consistently used good practice.

People and relatives we spoke with were happy with the quality of care they received and were happy living in the home. There were enough staff working at the service to keep people safe. The provider had conducted the necessary checks about their character to make sure they were safe to work in the home, before they commenced their employment.

People received their oral medicines when they needed them. However, we were not assured that people had received their prescribed creams correctly.

Staff had a good knowledge about how to recognise abuse and were confident to report this. However, accurate and thorough information in relation to how the staff needed to support people when they became upset and/or distressed was not always in place. This meant staff had an inconsistent approach when this occurred.

People received enough to eat and drink to meet their individual needs. Where there was a concern about people not eating and drinking enough, this was monitored and acted upon. People were supported with their healthcare needs.

The environment required improving for people living with dementia so that it was more stimulating and helped them orientate themselves around it. The provider had identified this and was actively working with the local authority to make the necessary improvements.

People had access to a number of planned activities to stimulate them and improve their well-being. However, there were missed opportunities with staff not always actively engaging or distracting people which would improve this further.

People and/or relatives had been involved in making decisions about their/their family members care when they started using the service. Staff practice in respect of involving people in day to day decisions about their care was variable.

Most staff were kind and caring but some staff practice regarding treating people with dignity and respect at all times was variable. Any complaints or concerns raised by people or relatives had been acknowledged and investigated.

The provider had good links with the local community that benefited people who lived in the home. They were continuously looking for ways to improve the quality of care people received.

We have made one recommendation. This is in respect of risk assessing the premises in relation to hot surfaces in line with relevant guidance.

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.

Risks to people's safety had not always been appropriately assessed or consistently managed well. Staff were not always vigilant to some risks posed to people. This placed some people at unnecessary risk of harm.

Staff knew how to protect people from the risk of abuse. However, the information available to staff on how to support people who became upset and distressed was not thorough. This meant they did not have a consistent approach when this situation arose to keep the person, themselves and other people in the home safe.

People received their oral medicines when they needed them but improvements are required to give the provider assurance that people also received their topical creams correctly.

There were enough staff available to keep people safe. The required checks had taken place before staff started working in the service to ensure they were safe to work within a care setting.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent had not always been sought in line with the relevant legislation.

Staff had received training in a number of different subjects. However, some of them demonstrated variable practice which meant people did not always receive effective care.

Improvements were required to the environment to ensure it was suitable for people living with dementia. The provider was aware of this and was working on making improvements.

People received enough to eat and drink to meet their needs and were encouraged to eat and drink sufficient amounts. They were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring but others demonstrated a mixed approach. People's confidentiality and dignity was not always respected.

People and relatives had been involved in initial decisions about the care provided but staff practice was variable in involving people in making day to day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were variable in their response to people's needs. Some staff engaged with people and provided them with stimulation to enhance their well-being but other staff did not which equated to missed opportunities.

People's needs and preferences had been assessed but some people's care records contained a lack of information to guide staff on how to meet their needs.

Complaints and concerns were recorded, investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not all systems currently in place were effective at ensuring people consistently received good quality care.

There was an open culture in the home. Staff and people felt listened to and able to raise concerns without fear.

There were good links within the community that the provider was keen to improve. The provider demonstrated a positive attitude to making improvements within the service for the benefit of people living there.

Dorrington House (Dereham)

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 26 and 28 September 2017 and was unannounced. On the first day it was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, one inspector visited the home.

Prior to this inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had received from the local authority quality assurance team. We also spoke with a social care and healthcare representative for their views on the quality of care provided at the home.

During the inspection visit, we gained the views of five people living in the home and four visiting relatives about the care that they/their relative received. We also spoke with five care staff and two kitchen staff, the provider and the registered manager. A number of people living in the home were not able to communicate their views to us, therefore we spent time observing how support was provided to them.

The records we looked at included eight people's care records and seven medicine records, five staff recruitment files and staff training records. We also looked at documentation showing how the provider assessed the quality of the service they provided.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated Safe as Good. At this inspection, we have rated Safe as Requires Improvement.

Risks to people's safety in various areas such as falls, choking, developing pressure sores and not eating or drinking enough had been assessed. Some people who had been deemed as being at risk of falls had the relevant equipment in place such as a bed low to the floor or a crash mat to protect them from injury if they fell. Other people had specialist equipment in place to protect them from the risk of developing a pressure sore or received pureed meals to reduce the risk of them choking on food. However, we found the management of some of these risks and others to people's safety was variable, therefore leaving some people at risk of harm.

One person had experienced two falls within the last three months. Both of these falls had resulted in the person sustaining a serious injury. Their risk of falling had been re-assessed following these incidents and it was stated in their care record, that staff needed to ensure the person had their walking frame near them at all times. However, when we observed the person sitting in a communal lounge, they did not have their frame next to them. We later saw staff bring the person their frame when they assisted them with personal care. We spoke with two staff about this. They gave us different explanations in relation to the use of the frame. One told us the person should always have their frame near them. However, the other said they had been told not to leave the frame near the person. This was for fear that it might encourage the person to try to walk when no staff were available. This confusion meant the risk to the person was not being managed in line with their assessed needs.

One person was seen walking in the main dining room. They did not have any footwear on their feet and were walking in their socks. We were concerned that this could pose a risk of falls to the person. A staff member walked past the person but did not intervene. We spoke with the registered manager. They told us the person should have shoes or slippers on due to the risk of falls but that they often took them off. Whilst it is accepted this may be challenging for staff, they were not always vigilant to the risk.

We observed one person trying to get out of their chair and walk. A table was in their way and they found this difficult to negotiate. The person was seen to be at risk of tripping. They called out that they wanted to move. There were two staff in the room. One was giving people drinks and they asked the person to wait. The other staff member was recording notes on a computer and did not intervene. The person continued to try to get up and attempted to get their leg over the table leg. The inspector had to ask a staff member to assist the person as they were concerned they might fall. This placed this person at unnecessary risk of a fall.

During lunchtime in one area of the home, we saw that a person was regularly coughing when they were being given food and drink. We were concerned this may mean they were having swallowing difficulties. When we asked the staff whether this person regularly coughed, we received mixed responses from them. Two staff told us the person often coughed when given food and drink but other staff said this did not happen. We spoke with the registered manager about this. They told us they were not aware that this person

coughed. They checked the person's daily records which did not indicate the person coughed when eating or drinking. However, we noted that staff had not recorded that this had happened on the day we witnessed it. Therefore we were not confident that this issue had been brought to the registered manager's attention and the risk appropriately assessed. The registered manager agreed to ensure the person was monitored closely so they could seek specialist advice if needed to keep the person safe.

Another person's care record stated that staff needed to encourage them to wear specialist protectors to protect their heels. This was because they had ulcers on one of their ankles and the protectors would reduce the risk of this area deteriorating. When we walked past the person's room, we saw they had removed them. The registered manager told us the person would often kick them off. However, we observed staff walking past this person's room several times within a 45 minute period. At no point did they enter the person's room and encourage them to replace the protectors. We had to alert a staff member to this who then re-positioned the protectors on the person's heels. This meant the staff were not doing all they could to manage this risk effectively.

In the morning on the first day of our inspection visit, we found two cleaning products within one person's en-suite bathroom. These were an antibacterial cleaner and an all-purpose cleaner. We spoke with the team leader and asked if it was safe for them to be there. They told us these items should have been locked away for the safety of people living in the home. They said they thought the items may have been brought in by the person's relatives who liked to clean the room but they did not know when this had happened. They confirmed the person had received personal care that morning and that staff should have removed the products. This demonstrated that staff had not been vigilant to this potential risk.

During our walk around of the home, we saw that in three people's rooms there were prescribed creams that were not being kept secure. We asked the registered manager whether they had assessed this was safe for people living in the home. The registered manager told us they had not completed any assessments in relation to this matter and were not aware this needed to be done. They said that no external organisations had raised this as an issue with them in the past. It is necessary that an assessment takes place to ensure that any topical medicines such as creams are safe. For example, from accidental ingestion, that they are stored at the correct temperature to be effective, that they cannot be tampered with or accessed by people without authorisation. As this had not been assessed we were not assured that these creams were safe to be left in people's rooms.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Another person was resting on their bed. The registered manager told us this person was at risk of falls and therefore, a pressure mat to activate their call bell was in place so staff could be alerted if the person got out of bed. When we walked past the person's room, they were attempting to get out of bed and requesting personal care. We stood on the pressure mat to alert staff that the person required assistance but it did not activate. We brought this to the attention of a staff member who could not work out why the mat was not working and sought advice from the team leader who subsequently fixed the mat.

We asked the registered manager if any checks were in place with regards to pressure mats working correctly. They told us that the team leaders checked these each day and that this was recorded within the electronic care record system. However, when the registered manager reviewed the system there were no records to say these had been completed for a number of days prior to our inspection visit. After the inspection visit, the registered manager told us that staff had confirmed they had checked the equipment that day and that the mat had a loose connection which was fixed when we brought it to their attention. They said the connection could have been dislodged by another person living in the home and this may

have been why it had not worked when we stepped on it.

When we walked around the home, we saw that some communal bathrooms and one person's en-suite we checked had some exposed pipework. One of the bathrooms had an uncovered radiator. When we touched the pipework and the radiator they were cold but we noted that in some bathrooms, the pipes did carry hot water. We asked the registered manager whether an assessment of the premises had been conducted in relation to exposed piping or hot surfaces. These can pose a risk of burns to people. The registered manager told us they were not aware that any such assessment had been made and that this had not been raised with them as an issue from any external organisations in the past. The provider also told us they had not conducted such an assessment with regards to these areas.

The provider and registered manager assured us that any exposed pipework within people's rooms or communal bathrooms did not pose a risk of burns should a person fall against them or touch them. The provider said that all exposed pipework within people's en-suites were cold pipes and that people were always supervised when in the communal bathrooms. However, we saw that people regularly walked around the home and could easily enter a bathroom without supervision.

We recommend that the provider conducts a full assessment of the premises in relation to the risk of hot water and surfaces in line with the Health and Safety Executives guidance dated September 2012, to ensure no areas of the home post a risk to people's safety.

All of the people we spoke with told us they felt safe living in the home. One person told us, "Yes, I feel safe because I can press my button at any time." Another person said, "Everything about this place makes me feel safe." The relatives we spoke with agreed with this. One relative told us, "I feel quite happy when I leave here knowing that she is safe." Another relative said, "I think she's safe because of all the security here."

All of the staff we spoke with demonstrated they understood what abuse was and told us they would have no hesitation in reporting any concerns if they had any. They said they would report these to the senior staff or the registered manager. This included if they witnessed any poor practice. Although most staff were aware of the different organisations they could report any concerns to outside of the home, they did not all understand the term 'whistleblowing'. Most were not aware of their rights if they chose to 'blow the whistle' on the home for any reason or if the provider had a policy in relation to this subject. The provider therefore needs to ensure that staff are fully aware of this process should they wish to use it.

After the inspection visit, the provider told us that their policy in relation to whistleblowing was displayed within the staff room for staff to access at any time. They also said that this subject was detailed within each staff member's contract of employment that they had to sign.

The staff told us that some people living in the home sometimes became upset and distressed. This may pose a risk to the person, other people living in the home and the staff. We asked staff how they managed these situations. They told us they used techniques such as distraction or removed a person from the area to help them calm down. However, the staffs response regarding what could cause a person to become upset and distressed and therefore, how they would support the person were inconsistent. For example, one staff member told us how they recognised that a person would become upset if they were in a room with a large number of people. They said they had noticed this agitated the person. However, another staff member we spoke with told us there were no triggers for this person. This could mean they may inadvertently place the person in a situation that would cause them to become distressed. The staff also offered different views on what would help the person calm down.

We therefore checked this person's care record in relation to how the home supported them when they became upset and distressed. There was a lack of information to guide staff on what they needed to do to support the person and keep themselves and others safe. Some of the information that staff told us they felt triggered the person's upset were not included. This could account for the differing views we received from staff about how to support the person. We checked another person's care record and found the same issue. We spoke with the registered manager about this. They told us they felt the care records contained sufficient information and that adding extra information would make them very long. However, they agreed to review them and add in all pertinent information to help staff manage these situations in a consistent manner for the safety of the people living in the home.

The people we spoke with told us they received their medicines when they needed them. One person told us, "I take 9 or 10 tablets a day and they always watch while I take them." Another person said, "Oh, it's always on time and they watch and make sure that I take them."

People's oral medicines were stored in a cupboard within a secure room for the safety of the people living in the home. The temperature at which the medicines were kept had been reviewed daily. This was to ensure the medicines remained safe to give to people. Records showed that people had received their oral medicines when they needed them. This included medicines such as Insulin or Warfarin. Medicines that required specialist storage were stored appropriately and an audit of two of these medicines showed that people had received them correctly.

There was information (PRN protocols) in place to guide staff on how to give people medicines that had been prescribed on a 'when required' basis. These advised staff on what actions they needed to take before considering the administration of this type of medicine. For example, to try to distract someone who was upset before giving them a sedative medicine. The team leader told us that this information was regularly reviewed when they carried out a monthly audit of people's medicines. However, some people's PRN protocols were dated over a year ago. We concluded they had been reviewed but the PRN protocols had not been updated to reflect this.

Where people were being given their medicines covertly (hidden in food or drink), the team leader told us they always tried to give them to the person first. If they refused, they said they would give then give them covertly. This is good practice. The medicines that had been prescribed to be given covertly had clear instructions about how staff needed to prepare them. This was to ensure they remained effective.

The medicine records showed that some people had prescribed topical medicines such as creams to treat various skin conditions. There was a lack of clear information in place to guide staff where and how they needed to apply this type of medicine. This was the same for creams that had been prescribed on an 'as required' basis. It is good practice to have clear instructions for staff to follow.

The medicine records did not show that people were having their creams applied as intended by the prescriber. The team leader told us staff recorded the application of these creams in people's daily notes. However, when we checked this we found this recording to be sporadic. Staff had not always recorded if they had applied a cream. Where they had, they had not always differentiated as to which cream they had applied. This was important as some people had a PRN 'as required' cream as well as a prescribed cream for certain skin conditions. This meant the registered manager and provider could not tell whether people were receiving their creams correctly. We spoke with the registered manager who acknowledged that the recording of creams needed to be more consistent.

Four of the five people we spoke with were satisfied there were enough staff available to support them when

they required this. One person told us, "Yes, there's enough staff for what I need." The relatives agreed with this. One relative said, "There's enough staff to support mother." Another relative told us, "We have seen nothing to make us think there is not enough staff." However, one person said, "No, I don't think there is enough staff." When you ring they don't come straightaway but when they arrive there is always enough staff to help me."

All of the staff we spoke with told us the home had experienced some challenges in relation to staffing levels but that this had recently improved. They said sometimes the home had less staff working than they needed but that this now rarely occurred. One staff member said when this happened they worked faster and smarter and took shorter breaks, therefore limiting any impact on people. Another staff member said two of the three areas of the home were 'merged' and that five staff worked across them instead of the usual six. They stated they could manage with this number when necessary.

We observed that there were enough staff working to keep people safe. For the majority of the time, staff were available to respond to people's requests for assistance and call bells were answer in a timely way. Staff were usually present within communal areas so they could monitor that people were safe.

The registered manager also told us they had experienced some challenges in relation to staffing. They said this had improved and they were currently recruiting more staff to work in the service. The provider told us that ideally they liked to have nine staff working during the day but that the staff could keep people safe with eight staff. The staff rotas we checked showed the home had usually had eight staff on shift in September 2017. These staff were supported by a support worker who also worked at breakfast, lunch and tea. Contingency plans were in place to cover unplanned staff absence. This included bank, existing staff and the registered manager who told us they also provided cover if needed.

The required checks had been completed before staff started working at the home. This included a Disclosure and Barring Service check. This is required to help the provider judge the character of the potential staff member and also to ensure they are not barred from working within a care setting. Photographic identification had been reviewed as had the staff member's health to ensure they could work within the home. References had been sought and obtained from the staff member's previous employer to help the provider judge their past working practice.

We observed that the fire exits in the home were clear to aid any evacuation that needed to be made. Fire equipment had been regularly assessed and tested. A recent audit had taken place by an external contractor who had found some issues in relation to fire safety. The registered manager was currently working on rectifying these.

The gas supply had been serviced and a certificate of safety issued by the engineer. Checks on lifting equipment had taken place in line with the relevant legislation. Regular checks of the water system had also taken place to reduce the risk of Legionella.

Staff were aware they needed to inform the team leader or registered manager of any incidents or accidents that occurred in the home. These had been recorded and the registered manager had investigated them in an attempt to reduce the risk of the incident from re-occurring.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated Effective as Good. At this inspection, we have rated Effective as Requires Improvement.

The registered manager told us that a number of people living in the home lacked capacity to make decisions about their own care and treatment. Therefore, the registered manager and staff had to work within the principles of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that the principles of the MCA were not always being followed.

We observed mixed practice in relation to staff seeking people's consent. Some staff were seen to do this but others did not always seek consent before they performed a task. For example, over lunch in one area of the home, the staff did not ask people if they wanted to wear a tabard to protect their clothing. They did not always support people to make a decision about what to eat or drink. Drinks were chosen for them without people being offered a choice. Although staff asked some people what they wanted to eat, where they had difficulty making a decision the staff chose for them without showing them the meals to help them make a choice. This was in direct contrast to another area of the home where people were showed their meals which is good practice.

The staff we spoke with had a mixture of knowledge in relation to the MCA. Some staff understood they always had to assume the person could consent to a decision and that if they couldn't, they then took action in the person's best interests. However, other staff did not demonstrate they understood these important principles and we found that these had not always been followed.

For example, one person whose care we looked at was diabetic. We asked the registered manager when the person had last received an eye check which is recommended in best practice guidance. They told us the person had not had one because they and the person's daughter had agreed this was no longer required. However, the registered manager had not formally assessed whether the person was able to consent to this decision. There was no record of who had been involved in making this decision in the person's best interests. It would be pertinent when making such a decision to involve a registered healthcare practitioner. Also, the relative was not able to consent to this decision on behalf of the person as they did not have the relevant Power of Attorney in place to enable them to do this.

Two people whose care we looked at, were receiving their medicines covertly (hidden in food or drink). We saw the GP had written to the home confirming they were happy for the medicines to be given covertly but there was no information about who else had been involved in making this best interest decision.

Another person had a pressure mat in their room. When we spoke with them they said they felt restricted by

the mat. Because the mat was in place, they said they didn't like to get up to go to their wardrobe or chest of drawers as an alarm would be set off and the staff would arrive. We spoke with the registered manager about this. They told us the mat was in place to protect the person from the risk of injuring themselves as they were at high risk of falls. They said the person had fluctuating capacity and that when they lacked capacity, the mat was put in place in their best interests. However, there were no records in this person's care record regarding this decision or whether they had consented to the mat being used when they had capacity or when they lacked capacity. Some of the staff we spoke with told us the mat was always in place to protect the person from the risk of injury. This was not respecting the person's wishes.

We spoke with the registered manager about our concerns. They told us they understood that any decisions they or staff made on behalf of people had to be in their best interests. We asked them to provide us with documentation in relation to four people whose care we looked at so we could determine whether the principles of the MCA had been followed when making decisions on behalf of people. The registered manager could not provide us with the required records. They could not therefore demonstrate that all practical steps had been taken to help these people make a decision themselves or to prove the person lacked capacity to consent to a certain action.

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

After the inspection visit, the registered manager told us they had spoken to the person who had given consent for the pressure mat to be in place at all times.

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). The registered manager had appropriately made applications for DoLS for some people living in the home. We looked at one that had been authorised by the relevant authority. It did not have any conditions placed on the home regarding the application.

All of the people and relatives we spoke with told us that staff appeared to be adequately trained. One person told us, "I have confidence in the staff when they help me get up and go to bed and bathe me." Another person said, "They seem adequately trained for what I need." A relative told us, "Yes, the staff are well trained." Another relative said, "I've seen nothing to indicate that they are not well trained."

All of the staff we spoke with told us they felt the training they had received was good. They said it provided them with the skills they needed to provide people with effective care. The staff training matrix (this details training staff have completed), showed that most staff had received training in line with the provider's requirements. Some of the subjects covered included but were not limited to; moving and handling, dementia and challenging behaviour, food safety, infection control, the Mental Capacity Act and fire safety.

Although records showed that staff had received training in a number of different subjects and the registered manager told us they were monitored closely in relation to their care practice, we observed that staff did not consistently demonstrate good practice when supporting people. Some staff were not sufficiently vigilant to risks to people's safety. Others were seen shouting over people that did not promote people's dignity. Some staff did not always seek consent from people or offer them choice.

We observed two staff use unsafe practice when assisting a person to move from a chair to a wheelchair. The staff used an underarm technique to do this and the person placed their hands on the front of their walking frame when standing. This not only increased the risk of injury to the person's arms as they are assisted up

but also of falls should the frame be inadvertently pulled forward. We also saw that some staff did not always engage effectively with people living with dementia. A professional we spoke with during the inspection also raised this as a concern with us. They told us they found staff variable in their approach to people with some being very good and others not responding to people effectively.

Due to our observations, we spoke with the provider's training manager about what training they delivered and how they did this. They told us they were responsible for providing 'in house' training in most subjects, the exceptions being emergency first aid, the control of substances hazardous to health and medicines management which were completed by an external company. They confirmed the 'in house' training was delivered by DVDs and staff completing a booklet. This they later checked to ensure the answers staff provided were appropriate. Some of the staff we spoke with confirmed this was the way they completed their training.

As the provider, training manager and registered manager told us the home was a specialist dementia home that would admit people with advanced dementia, we were concerned that staff had not received sufficient training in respect of dementia and challenging behaviour. We spoke with the registered manager and provider about this. The registered manager told us there were two dementia coaches working within the home who were available to staff should they have any questions about dementia. The provider told us these staff had completed a training programme that had been provided by the Norfolk and Suffolk Dementia Alliance. However, the provider told us they had recognised that staff required more specialist knowledge in relation to dementia due to people's needs increasing and becoming more complex. They were therefore in the process of having two further staff trained by external professionals so they could pass on this specialist knowledge to staff.

We asked the registered manager and provider how they monitored staff were competent to perform their role. The registered manager told us staff were continuously monitored each day and that any issues were dealt with immediately. They confirmed that staff received one supervision a year and one appraisal. However, as we saw a number of issues with staff practice during the inspection and we have therefore concluded the current level of monitoring is not sufficient.

The home consisted of three different areas called Highland, Adelaide and Woodlands. All were self-contained units but the doors between Adelaide and Woodlands were kept open. The doors to the Highland unit were kept shut, accessible by a key code. Some staff told us this was because people's needs were higher in this area. There was a secure garden space outside that people could safely access. One person told us, "I go out in a wheelchair with my daughter." Another said, "If it's nice we walk around the garden."

The use of contrasting colours in some areas of the home was evident to help people identify and orientate themselves. For example, bannisters in one part of the home were a darker colour to the wall to help people see it more clearly. People's rooms had numbers on them and a picture to help them orientate themselves back to their room. Written signage was evident on communal bathrooms and toilets. However, this was not the case in all parts of the home.

In some areas the bannisters were the same colour as the walls and there was no signage on communal bathrooms. The registered manager told us this was because some people pulled the signs down. We saw that these had been blue tacked on the door. We asked the registered manager is they had considered screwing signs, both written and pictorial on the doors. They told us that these were also pulled down. We observed that some people found it difficult to find the communal toilets and bathrooms. In the lounge within the Highland unit, we noted that three light bulbs were not working. This reduced the amount of light which may have made it difficult for some people to orientate themselves.

There were some engaging murals that had been painted on some walls. For example of a bird in a tree but again, this type of sensory stimulation was not evident throughout the home. There was a lack of signage overall within the home directing people to communal areas such as the lounge or dining room. We did not observe any calendars or clocks with large numerical faces to help people orientate themselves to time and place. In one part of the home we saw that the menu for that day had been written on a blackboard but in another part, the menu listed related to four days prior to our inspection.

There was an indoor garden area within the home. This included a number of tubs that were set at a high level. Staff told us that one person used to enjoy tending to the plants in this area. However, this had ceased some time ago and all the plants had died. This was clearly not being used as an activity and made that area of home look untidy.

The provider told us that in the past, there had been a number of sensory areas within the home but that they had been advised to remove these after an external infection control audit had been conducted. This they said, was because the external infection control specialist has judged the items to increase the risk of the spread of infection. They were now working with the local authority quality assurance team at improving the environment. They had a number of good ideas about how they could do this for the benefit and well-being of the people living in the home.

People were supported to eat and drink enough to meet their individual needs. People and relatives were mainly positive about the food that was served. They all said they or their family member received enough to eat and drink. One person told us, "The food is very good. I don't know if they would give me an alternative because I've never been faced with anything I didn't like." Another person said, "The food is okay but it's often not quite hot enough." A further person told us, "The food is alright. The problem is I've lost my taste." A relative said, "The food is okay. There are three courses at lunchtime and there is a choice of main course." Another relative said, "The food is very good and she can have it in her own room if she wishes."

We spoke with the cook who demonstrated they had a good awareness of people's dietary needs. Where people had specific dietary requirements, such as needing a pureed diet to protect them from the risk of choking, clear and detailed information was available to guide the kitchen staff on how they needed to prepare this to meet people's needs. The cook told us the communication from the registered manager in respect of people's diets was good so they could ensure they prepared people's meals accordingly.

Three courses were on offer at lunchtime that included soup as a starter. There was then a choice of two main meals and desserts. At breakfast and for the evening meal, there was also a choice of food that people could have. The cook told us they made alternatives for people if they did not like what was on offer. Drinks and snacks, including fresh fruit were regularly offered to people and they were given a choice of biscuits to eat with their hot drinks.

Where people were underweight, the cook told us they fortified their foods with extra calories and that people could have smoothies to increase their calorific intake. We saw that the home had been given an award from the local authority for providing good, nutritious meals. The local authority environmental health team had also awarded the home the top rating of five stars in November 2016 in relation to food safety. Throughout the inspection, people had access to plenty of fluids and those people who required assistance to eat and drink received this. The registered manager and the staff monitored people who were not eating and drinking and took action to increase their intake.

Most people whose care we looked at had been supported to maintain their health when required. People told us the staff would contact a GP or other healthcare professional if they felt unwell. The staff we spoke

with demonstrated they had a good understanding of the different types of healthcare professional they would need to involve when necessary. Records showed that professionals such as GPs, dieticians, chiropodists and district nurses were contacted when needed. An external professional who visited the home regularly told us staff always followed their instructions to help people improve or maintain their health.

The staff we spoke with and records showed, that action had been taken to protect people from further injury when they had fallen if they had indicated they were in pain. When this happened, staff had immediately contacted the emergency services and did not move people which could exacerbate the injury. Where people had hit their head following a fall, staff regularly monitored this so they could contact the emergency services if their health deteriorated. Some relatives told us they had been consulted as to whether they were happy for their family member to have a flu jab in time for the winter.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated Caring as Good. At this inspection, we have rated Caring as Requires Improvement.

All of the people told us they felt staff were kind and caring and treated them with dignity and respect. One person told us, "The staff are always pleasant and very caring. They treat me with respect and they maintain my dignity when they are helping me." Another person told us, "The staff are very nice. Oh yes, they treat me with respect." The relatives we spoke with agreed that the staff were kind and caring. One relative said, "The staff are friendly, caring and very supportive." Another told us, "We can't find any fault with the staff. We were very new to this kind of place and we were very pleasantly surprised at the staff here."

We observed mixed practice from staff in relation to their caring approach and treating people with dignity and respect. One staff approached a person when they were upset. They held their hand and offered them comfort. Another staff member assisted a person into the dining room. They asked where the person wanted to sit and their interaction with the person was warm and friendly. One person was seen having a conversation with staff about their hair. The person had just had this styled and the staff member paid them a number of compliments that the person appreciated. Before staff entered people's rooms, they knocked on the door which demonstrated a respect for people's privacy.

People's birthdays were celebrated with the cook making them a special cake. Some staff spoke to people referring to them by the preferred method of address. People's rooms were personalised to their own taste and they were able to have items in their rooms that were special to them and gave them comfort. Minutes of staff meetings showed that staff were kept up to date with people who had moved on from the home. Staff were told how these people were and how their well-being was. This demonstrated a caring approach and that staff were interested in people they had provided care to in the past.

During lunchtime in the main dining room, we found this to be an enjoyable experience for people. The staff were attentive and encouraged people to eat and drink. The room was bright and spacious. Food was served from a hatch to the kitchen. This meant that the smell of the food could help stimulate people's appetites. People were given plenty of time to eat and enjoyed their meal. However, when we observed lunch another area of the home, found the experience for people to be less pleasant.

When we entered the dining room there was very loud pop music playing. Four people were sitting at the dining tables. None of them were engaged with the music. One person had their head in their hands. We asked the staff to turn the music down which they did as loud music can be overpowering for some people living with dementia.

A staff member sat down with one person and reminisced with them about the past. The person looked to enjoy this as they were smiling and laughing. However, when a different staff member assisted this person to eat, they made limited effort to engage with the person. The person asked the staff member a number of questions, demonstrating they clearly wanted to engage with them. At one point the staff member placed

their elbow on the table and rested their head in their hand which made them look bored. Another person in the dining room was sat too low and too far away from the table to enable them to easily reach their food. They managed but found this difficult. Staff had not noticed this and did not rectify the situation.

Some staff talked about people's care within a communal lounge in front of them or other people. This did not protect people's confidentiality. One staff member who was on the computer shouted to another, '[Staff member], will you feed [Person]'. Staff also referred to people who required assistance to eat as 'feeds' or those that required assistance to the toilet as 'toilets'. One staff member said, 'We need to do the toilets in here now.' When one person got up and walked across the lounge a staff member said very loudly in front of everyone, 'Are you off to the toilet [Person's name]?' None of these examples promoted people's dignity. Later in the day, one person was observed to be upset and distressed. They were continuously shouting out. When the staff member approached them they said, "Why are you shouting?" Although not done in a harsh way, this was not an appropriate response to someone who is living with dementia and who is distressed.

None of the people or relatives we spoke with felt they were involved in making decisions about their care. However, they were not unduly concerned about this. One relative told us, "I'm not formally involved but we do discuss her health on a day-to-day basis. They recently asked me if they could give her the 'flu jab."

Before people moved into the home, they and a relative if necessary were invited to make decisions about how the care was to be received. People and relatives were able to take a look around the home first to see if it was where they wanted to live. The registered manager told us that people and relatives were invited to discuss the care that was being received every few months or whenever they wished to discuss this. We saw mixed practice from staff in relation to involving people in making decisions about their care.

The registered manager told us that information about the home could be provided to people in a number of different formats. This included large print or braille if necessary. They said that for one person, they had purchased a white board that staff used to communicate with them by writing things down. They were looking to invest in a tablet instead for this person to use to improve this method of communication. This meant the registered manager and the provider were working within the Accessible Information Standard. This standard has been in place since 1st August 2016. It legally requires all organisations that provide NHS care and/or publicly-funded adult social care to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated Responsive as Good. At this inspection, we have rated Responsive as Requires Improvement.

All of the people we spoke with expressed they were happy that their care needs and preferences were being met. One person told us, "I don't need any help so I get up and go to bed when I want to." Another person said, "They put my pyjamas on at the same time every evening but I don't have to get into bed. I just call them when I'm ready." The person explained they were happy with this arrangement.

We saw mixed practice in relation to staff being responsive to meet people's needs. One person was observed to be in an uncomfortable position. Staff noticed this and helped them to re-position themselves. Another person required assistance with personal care and staff immediately helped them with this. Records showed that some people's more complex continence needs were being monitored and met as were their eating and drinking and personal care needs. When we arrived for the inspection, everyone was up and dressed in a reasonable time in relation to their own preferences. Another staff member was seen handing a person a blanket that gave them comfort and calmed them when they were upset.

However, staff did not always recognise or intervene to meet some people's needs. One person was seen looking confused when being near a communal toilet. They opened and shut the door and we heard them say that they were not sure whether to use it. A staff member saw this but walked straight past the person without intervening. Another person stood up in a lounge, pointed to some furniture outside the patio doors and said, "It's a lovely sunny day, we could all go and sit outside on these chairs." A staff member was standing next to the person. They did not acknowledge this or ask the person if they wanted to go outside. Instead they walked away. The person then continued to walk around the room at which point the same member of staff asked them to sit down.

We saw another person was slumped forward in their chair. They looked uncomfortable and were sitting on the edge of the chair with their chin on their chest. Even though there was a staff member present, they did not check the person was alright or ask them if they wanted to be re-positioned into a more comfortable position.

People's needs and preferences had been assessed before they moved into the home. There was good information to tell staff about people's preferences and routines such as when they liked to get up or go to bed. There was a summary of people's needs and then more detailed care plans in relation to how the care needed to be delivered to meet these individual needs. Areas covered included but were not limited to: assisting the person to move, personal care, eating and drinking, continence, social needs, communication and cognition. However, we found that some people's needs had not been planned for and information in some care records was incorrect or contradictory. It is important that staff have clear and accurate guidance as this reduces the risk of staff providing people with incorrect care.

Some people living in the home had diabetes. There were no plans of care in place to guide staff on how to

meet this need. There was nothing to say what health checks people required in relation to their diabetes, when these were required or how staff could recognise if someone was unwell or when they might seek treatment from a healthcare professional. The registered manager told us that it had not been raised with them before that care plans were required in respect of people's needs in relation to diabetes, but they agreed to review this and put them in place.

Staff were assisting another person with aspects of their continence. Again, there was no specific care plan in place to guide staff on how to do this safely or what to look out for to indicate there may be a problem. This person was assisted to go outside to smoke. There was no clear information about this need. For example, how often the person liked to go out, how many cigarettes they enjoyed smoking or whether they could do this themselves or required staff support.

It was written in one person's care record that they required a high fat diet however, we saw the person was not underweight and this could therefore be confusing for staff. Another person's care record stated in one part they had no creams prescribed as at 1 September 2017 but in another, said a cream had been prescribed to be applied to the person's legs and feet. This person's care record also stated they did not use any aids in respect of continence management but a different area discussed the need for the use of incontinence pads. For another person, the summary care plan stated they needed to be weighed weekly but we saw this was occurring monthly. The team leader told us the care plan was incorrect as the person only required to be weighed monthly.

The registered manager told us they had identified that people's care records required more accurate information in them and that they were currently in the process of completing this.

Prior to the inspection, we had a concern raised with us that there was little stimulation for people and this was leading to people becoming agitated and upset. We found that people had access to some activities but that this could be improved to ensure that people received regular support to participate in meaningful activities.

The registered manager told us there were a number of planned activities available to people each week. We saw there were three to five activities available each week. These included outside entertainers. Activities on offer included but were not limited to: exercise, crafts, biscuit decorating, singing, watching movies with popcorn, pampering and one to one sessions. People had recently had the opportunity to pet some guinea pigs and miniature donkeys. The registered manager had ensured these animals had also visited people in their own rooms if they wanted to see them. A summer fete had also taken place which staff said people had enjoyed. Parties were organised and we saw a Halloween party was currently being planned. For people who had spiritual needs, a monthly church service took place.

Outside of the planned activities, the registered manager told us it was the staff's role to engage with people in activities to enhance their wellbeing. The staff we spoke with told us they did get time to do this. One staff member said at the end of their shift they often sat with a person and went through photographs with them so they could reminisce about the past. Another staff member told us how they engaged people in puzzles, skittles or pampering. However, one staff member said they found it more difficult to engage people in activities as their dementia had progressed. They said they had not received any specific training in what sort of activities may be meaningful for people living with dementia.

The people we spoke with told us they lacked stimulation and were sometimes bored. One person said, "No, they don't have any activities here." One person we spoke with told us they liked steam trains. When we spoke to them about this they were very knowledgeable about the subject and their face lit up. They told us

"Generally I'm bored and I don't want to join in the activities in the lounge." They said staff did not engage with them about their interests. When we checked their care record, there was no mention of their interest in steam trains and two staff we spoke with were not aware of this. This was a missed opportunity to enhance this person's wellbeing.

During our observation in the morning on the first day of the inspection visit, we saw staff sometimes engage people in activities such as playing cards or skittles. However, the time spent doing this was minimal. Other people were seen reading a newspaper or doing a cross word but others were not engaged with any activities and received little stimulation or distraction. This was despite staff regularly sitting in the communal areas with people or passing them as they were walking around the home. A professional we spoke with said when visited home they often found people walking around with no engagement from staff. This meant there were missed opportunities to for people to participate in meaningful activities. The planned activities over the course of our inspection visit was a relatives and residents meeting and a pamper morning.

Some people were given items that gave them comfort such as toys or blankets but there was a lack of items for people to freely pick up, touch and feel that may provide them with sensory stimulation. The provider told us they had recognised this and were looking to improve sensory stimulation for people.

None of the people we spoke with said they had had to make a complaint in the past. They all told us they were not aware of the formal complaints procedure but said they felt confident to raise any concerns they had directly to the registered manager. One person told us, "I don't know of a complaints procedure but I suppose I would speak to the manager." A relative said, "I've never had to complain but I would just go and see [registered manager]. She is very approachable."

The provider had a system in place to record complaints. Most records showed that these had been investigated and appropriately responded to. However we saw that for one concern raised, the provider's response had been defensive and lacked empathy for what had happened to a person living in the home.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated Well-Led as Good. At this inspection, we have rated Well-Led as Requires Improvement.

The provider's current systems to monitor the quality and safety of care provided and to mitigate risks to people's safety were not all effective at identifying issues. Furthermore, complete and accurate records in relation to some people's care had not been maintained.

The provider and registered manager had not ensured there was a system in place to identify whether prescribed creams were being applied. This was not being checked as part of the regular audits of medicines. Due to this, they could not be assured people were receiving these as intended by the prescriber.

The registered manager had completed a health and safety audit in July 2017. A number of hazards had been identified but these had not included exposed pipework or unsecured creams. They told us they were not aware that these were potential risks to people's safety.

A risk assessment of hot surfaces had taken place in January 2017 but had not considered exposed pipework or radiators in the building. Therefore a robust risk assessment in relation to this area had not taken place.

At our last inspection, we found that the Mental Capacity Act 2005 was well understood by staff and that the necessary documentation was in place to demonstrate the Act had been complied with. We also found the care plans in place were clear, accurate and covered all appropriate areas such as diabetes care. However, we found this was not the case at this inspection and therefore, the provider had not ensured systems were in place to maintain consistently good quality care practice.

During the inspection, we found the quality of staff practice to be variable. Some staff demonstrated good practice whilst others needed their practice improved. The registered manager told us there was no formal system in place to monitor staff performance but that they monitored this daily through observation. However, this was not proving effective at ensuring staff consistently followed good practice.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other audits had taken place and we found them to be effective. This included audits in relation to infection control and fire safety. The registered manager had conducted audits of some people's care records and had recognised that their content required improvement. The registered manager also completed an analysis of incidents and accidents that had happened in the home. They had taken appropriate action where necessary such as referring people for specialist advice or providing people with particular equipment to reduce the risk of the incident re-occurring.

All of the people and relatives we spoke with were happy with the quality of care provided. All said they would recommend the home to others. One person told us, "Yes, I'm happy living here." Another told us, "Yes, I'm happy. Perhaps content would be a better word but I would recommend it." A relative told us, "She is happy living here and I would definitely recommend it." Another told us, "She appears to be happy here."

Relatives told us communication with them was good about what was happening in the service. We saw they received a regular newsletter informing them what had happened and of up and coming events that they or their family member could participate in. These were also available to people living in the home.

Everyone we spoke with told us they felt there was an open culture and that staff and the management team were approachable. One person told us, "Yes, I know the manager and I see her regularly." Another said, "I know the manager. She is a very nice lady and I often see her around the home." We saw the provider was displaying the rating from the last inspection which showed they were being open and transparent.

The staff agreed with this. They said they were happy working in the home and that they could raise any concerns without fear. They told us they were confident the management team would deal with any concerns they had and said they felt listened to and valued. Some staff told us how they had been promoted within the home. They also said they were supported to undertake qualifications in health and social care. Staff said they all worked well as a team to support people living in the home.

Staff meetings were held regularly. Minutes from these meetings demonstrated that staff were praised when they had done a good job and compliments from people and/or relatives were shared with them. Various issues were communicated to staff including any incidents or accidents that had occurred. Staff were reminded to be vigilant in some cases, such as ensuring external doors were closed to protect people's safety. This was in response to some people managing to leave the home and demonstrated that learning had occurred.

People were involved in the running of the home and were actively asked for their ideas on how the provider could improve the quality of care they received. We saw that people had been consulted about the quality of the food. Some has suggested they would like salad on the menu as an alternative and healthy snacks. This had been listened to and implemented. People and relatives were involved in a regular forum called 'Friends of the Home'. These people met regularly to discuss ideas about how they could raise funds for activities that would benefit the people living in the home. Relatives and residents forums were also held regularly and we saw that people's suggestions were readily taken into account and acted on.

A survey was sent to people for their feedback on the quality of care. We read some of these and saw that in the main, they were very positive. The registered manager analysed these responses and took action where needed in response to people's suggestions such as activities they would like to participate in.

The provider and registered manager were keen to make some improvements within the home. This included to the environment to make it more effective for people living with dementia. The provider was also investing in making other cosmetic changes and we saw they had already updated a lot of furniture in the home. They were looking at improving the use of technology in relation to pressure mats and installing a new call bell system. This they said, would help them monitor staff response more effectively when people requested support.

Links with the local community were in place. This included with the local church where representatives visited to provide people with a church service. Two pupils from a local school had recently completed work experience which the provider told us both people living in the home and the pupils had enjoyed. The

provider was also engaging with the community with the view of finding a number of volunteers to work in the home to improve people's well-being.

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 Consent had not always been sought in line with the relevant legislation. Regulation 11 1, 2 and 3.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety had not always been assessed or appropriate actions taken to mitigate risks. Regulation 12, 1, 2 (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Not all the systems in place were effective at identifying or mitigating risk to people's safety. An accurate, complete and contemporaneous record had not always been kept in relation to people's care and treatment. Regulation 17, 1, 2 (a), (b) and (c).