The Windmill Care Home

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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 25 October 2017 and was unannounced. The Windmill Care Home is a residential home for up to 29 older people, some of whom may be living with dementia.

At our previous inspection in October 2014, we rated the service as good overall.

During this inspection, we found that the registered provider was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staffing, governance, consent, safe care and treatment, person centred care, and privacy and dignity. You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and registered manager had failed to recognise potential harm to people using the service. Quality assurance and auditing mechanisms did not identify concerns we found during the inspection. Accidents and incidents were not analysed sufficiently to identify trends and patterns and to ensure people were kept safe.

Infection prevention and control procedures were ineffective and we found that hygiene was poor across the service. Environmental risks had not been identified by the service.

Improvements were needed where people were receiving medicines on an 'as required' basis to ensure these were only given when needed. Covert medicines also required clarity as to the method of administration, and how regularly they should be reviewed.

Staffing levels were not sufficient in order to meet the needs of people in a timely manner and keep them safe at all times.

Care plans contained detailed information reflecting people's individual needs and preferences. However, two of the care plans we looked at had not been recently reviewed in all areas, and not all guidance was in place to help staff support people effectively.

People's privacy and dignity was not always upheld. We observed some practices' which compromised people's privacy and dignity.

The registered manager had not applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. Best interests documentation was not always in place where

decisions had been made on behalf of people who lacked capacity.

Improvements were needed with the mealtime experience, and we have made a recommendation about this.

There was an activity co-ordinator in the service. However, the provision of activity was not sufficient to meet the individual and specialist needs of all people using the service.

The provider had not maximised the suitability of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

There was a complaints procedure in place. People and their relatives felt able to complain if they had concerns they wanted to raise.
People's nutritional needs were monitored, and people received support to manage a healthy diet where required. People were referred to other health care professionals in a timely manner to maintain their health and wellbeing.

Staff were aware of their responsibilities in relation to safeguarding people, were aware of the types of abuse they may come across. Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people in the service.

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.

Staffing levels were not sufficient to ensure that they were meeting people's needs at all times.

Systems were in place to manage people's medicines. However, improvement was needed where medicines were given covertly and 'as required'.

Infection control procedures were not effective. We found poor standards of hygiene across the service.

Risks had been assessed and guidance provided to staff on how to manage risks and keep people safe.

Staff knew how to protect people from abuse, and who to report concerns to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Deprivation of Liberty Safeguards had not been applied for when people who lacked capacity to consent, had their liberty restricted. The service was not following the principles of the Mental Capacity Act 2005.

Staff were trained in subjects relevant to the people they were caring for.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring

People's privacy and dignity was not always considered fully.

People told us that the majority of staff were kind and caring, but some people told us that the staff approach could vary.

Resident meetings were not held in the service as a means of obtaining people's views on the care they received.

Relatives and visitors could visit at any time and there were no restrictions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provision of activity for people was not sufficient to meet the individual and specialist needs of all people using the service.

Care plans were detailed and person centred. However, some areas of people's care plans had not been reviewed regularly.

There was a complaints procedure in place. People and their relatives felt able to complain if they had concerns they wanted to raise.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems had not identified where quality and safety had been compromised. This placed people at risk of harm.

Environmental risks needed addressing so people's safety was not compromised.

Staff were confident to raise concerns with the registered manager, and told us they felt listened to.

The Windmill 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 25 October 2017, was unannounced and undertaken 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.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with quality assurance and local safeguarding teams.

During the inspection we spoke with six people living at the service, one relative, and two health professionals. We spoke with the registered provider and registered manager, and four members of care staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection, we had received information that people were not being regularly attended to when they were receiving care in bed. This included concerns around regular repositioning and continence requirements.

At 9.30am we found that one person had not been attended to since 4.30am. The person was asleep, and there was an odour consistent with requiring a change of continence aid. We asked a staff member if they had been attended to since the 4.30am check, and they confirmed they had not. We requested they were seen to promptly, and at 10.30am staff recorded on the repositioning records that they had carried out personal care. This meant that the person had not been attended to for six hours. We checked the repositioning records kept in the person's room and found that staff were not routinely completing these records. Records showed that on some days the person had not been checked for between five to nine hours. Additionally, the records in the person's room did not specify how often the person should be repositioned.

We brought this to the attention of the registered manager who told us they were confident the person was regularly repositioned, but staff were not completing the charts to show when they attended to the person and this had been an on-going issue. They acknowledged the poor standard of care we found, but informed us the person had no pressure ulcers which would indicate a lack of regular repositioning.

Infection control procedures were not effective. For example, we found dust and debris under chairs, a used continence aid left in a communal bathroom, a hoist with unclean footplates, a crash mat with a sticky substance on, and toilet brushes sitting in contaminated water. We also found that some commodes were not being sanitised thoroughly. We brought this to the attention of the registered manager, and also asked for the local infection control team to visit the service.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We asked people if they felt there were sufficient staff on duty. One person told us, "I don't think there are enough staff. The staff get very busy at times but I do understand and I'm mostly happy to wait." Another said, "Sometimes there's not enough. They [staff] can be difficult to get hold of."

We spoke to staff about their views on the staffing levels. One staff member told us, "We need more staff in the afternoons, it's very hard then. The mornings are okay we have five staff, but on the late shift only four. Plus one finishes at 8pm, so that leaves only three staff. The impact is that people sometimes don't get to bed at the time they want." Another said, "I find the work very non-stop. Feels a bit under-staffed with many mobile people who are prone to falls. I would prefer to have enough staff to give closer assistance to these people and to ensure that people have drinks. Sometime people have to wait for assistance. Pinch times are around lunch, getting everyone toileted and to the dining area, lunch can be late". A third said, "We encourage people to continue to be mobile here which is good, but the downside to that is they are at more

risk of falling."

We observed that the majority of people living in the service were mobile, many of whom were living with dementia. This combination puts people at greater risk of falling. We observed one person in the dining area repeatedly trying to sit down where a chair was not positioned correctly, and which they could have fallen from had we not intervened. Due to the high number of falls in the service, we were concerned that had someone rang their call bell because they had fallen, staff may not be able to react quickly enough to protect them from further harm.

The service was spread across a ground and first floor with long corridors which further impacted on staff being able to respond promptly. However, the registered provider had not taken this into account when considering the number of staff required to meet people's needs.

The registered manager told us there were between five and seven people who needed two members of staff to support them with their care needs. We were concerned that given the number of people requiring two staff, there had been no consideration of the impact on others who may need assistance at the same time, particularly during the night when only two staff were available. If two staff were needed to assist a person to move or to use the toilet, there would be no one available to monitor the welfare of other people in the service, many of whom were at high risk of falls. Additionally, we saw that there was an increase in falls between the hours of 6pm to midnight. However, this information had not been used to consider the deployment of staff, or to increase staffing levels during these times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Prior to the inspection we received information which suggested that people were not receiving their medicines, and that tablets were often seen on the floor in people's rooms. During our inspection we did not observe any concerns in relation to this. People told us they received their medicines safely. One person said, "Oh yes I have to have my medicines on time. They [staff] make sure I take them but so do I." Another said, "All my tablets are given to me, they watch me take them." We observed the medicines round. The staff member dispensing medicines in the dining room before lunch stayed with each person while they took their medicines and explained in some cases what they were taking.

We reviewed the systems in place for managing people's medicines, and found some improvements were needed where people were receiving medicines on an 'as required' basis. There was not always sufficient information on when to administer these types of medicines. For example, we found three people were on medicines to reduce agitation. The generic phrasing of, 'for chaotic episodes' was used for each person. This did not describe how each person presented at times of distress, or what interventions which may work to reduce the agitation before the medicines were considered. We noted that these were being used on a frequent basis, but having more detailed information would reduce the risk of medicines being given when they may not be needed.

Where people were receiving their medicines covertly (hidden in food or drink), the method of administration was not always documented. Additionally, we found that mental capacity assessments had not been carried out to demonstrate that people lacked capacity and that it was therefore in their best interests to administer their medicines covertly.

Medicines which needed to be taken on a particular day of the week were highlighted within medicine administration records (MAR) to ensure all staff were aware. Rotation charts were in place for people who had pain relief patches applied, to ensure the site of application was varied to avoid irritation of the skin.

Where people needed medicines at a specific time of the day, a fob alarm was set so staff could ensure that the medicine was given at the correct time. We saw that MAR's were accurately and consistently signed to show what medicines people had been given. Medicines (including controlled drugs) were stored securely, with appropriate facilities available for temperature sensitive medicines.

Some products had not been stored securely. For example, we found a powder which was used to thicken drinks in one person's bedroom. Ingestion of this substance can cause fatal choking. The registered manager took immediate action to ensure this was stored securely.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated in the records. These included mobility, falls, nutrition, skin integrity and depression in dementia. Outcomes of risk monitoring informed the care planning arrangements, for example weight loss prompted onward referrals to dietetic services.

Risks to people injuring themselves or others were reduced because equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria. The provider told us they had recently had a new fire alarm system installed which in the event of a fire, shows which areas of the building are at risk via a visual panel. Personal emergency evacuation plans (PEEP's) were in place. These showed the support people required to evacuate the building in an emergency situation.

Staff were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member told us, "Abuse can be physical, financial or verbal. If I saw staff being inappropriate with people I would pull them up. I would whistle-blow." Another said, "I could pick up signs from the resident. We know people well, so we would know if they were quieter or acting out of character. Once a staff member spoke to me about a resident in a derogatory way, and I took action on that, I spoke to the manager."

We saw that several staff were overdue safeguarding training, due to this being cancelled at the last minute by the trainer. However, the registered manager was trying to secure another date as soon as possible. Additionally, new staff coming to work in the service had been asked questions during their interview about adult abuse, the types of abuse they may come across in their work, and different scenarios to test their knowledge.

The service followed safe recruitment practices. Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) had been undertaken before new staff started work. This ensured that new staff coming to work in the service were suitable for their role.

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 decision made on their behalf must be in their best interests and as least restrictive as possible

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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 MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

Where people were having their medicines administered covertly, (crushed and given to them in food or drink without their knowledge) documentation was in place to show that relevant people (such as a GP, family members and staff) had been involved in making the decision. However, we found that one had not been reviewed since April 2016, and there was no review planned. We also found there were no formal mental capacity assessments where people were unable to make a decision about their medicines, or indication of discussions that led to this being agreed. The continued need for covert administration must be regularly reviewed within specified timescales as should the person's capacity to consent. We found this was not in place.

We saw that a capacity assessment had been completed for one person following discussion with a family member. It noted that, "If GP feels it is in the [person's] best interests to go to hospital family want to be informed before this happens and they will make the decision". There was no information relating to the family members holding legal representation for this person, or if they had the authority to make decisions on the person's behalf in relation to their health. There was a lack of formal best interests processes in place, which potentially left the person at risk if the family disagreed with the GP. We found another example of this, where family members had been documented as people to contact for any health related decisions. Again, the family members held no legal authority to make these decisions on the person's behalf.

The home had closed circuit television (CCTV) installed in the corridors and front entrance of the service. Three people told us they knew it was there and were happy with it. However, the majority of people were living with dementia, and would have been unable to understand or consent to the use of this. There were no mental capacity assessments or best Interests decisions in place in relation to the use of this.

The registered manager did not demonstrate to us in discussions that they had a full understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). This meant we were concerned that people could have their rights infringed or be deprived of their liberty inappropriately. There were currently no applications made for DoLS, and there were people living with dementia, under constant supervision and unable to leave the service where DoLS applications should have been made. This meant that we could not be confident that the provider was aware of their duties and responsibilities under the deprivation of liberty safeguards

and that people's human rights were respected.

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

We observed staff asking people for consent prior to assisting them with tasks such as administering medicines, assisting people to eat, and deciding where to spend their time. Staff had a mixed understanding of the principles of MCA and DoLS. They understood why they needed to
gain consent from people to provide care, but were not knowledgeable about what DoLS meant in practice. This knowledge would enable staff to recognise when to take action, for example if a person's needs changed, or if a person moved into the service who needed support in this area.
One staff member said, "If people refuse help we sit and listen, try to explain. But it is their choice at the end of the day. We can always help them later on in the day if they prefer." Another said, "[MCA] is all about people's ability to express their preferences. Don't know much else."

People were supported to eat sufficient amounts and maintain a balanced diet. Where people required assistance, they were supported to eat and drink. We saw that people's food preferences as to what their likes and dislikes were reflected in their care plans, as well as how to prepare certain foods, such as pureed meals, and thickened fluids. People had been referred to speech and language therapists where specialist advice had been required.

We asked people if they enjoyed the food. One person told us, "The food's brilliant, I can't complain. We get a choice and you can have something else but it's generally okay." Another said, "It's alright. I'm quite easy to please. We get a choice of two things at lunchtime and you can ask for something else if you don't want what there is but I'm mostly satisfied." We observed during breakfast, that some people were having porridge whilst others had chosen to have a cooked breakfast.

We observed the lunchtime meal. There were 19 people being served lunch in the dining room and three people in one of the lounges. Other people were in their rooms and we saw lunch was being taken to them. There were no tablecloths set up, and staff dispensed a choice of squash into plastic cups. The room was quiet and no music was playing. Staff were available in the dining area and supported people to eat, but the pace was slow and there was no explanation to people of what was on the fork to guide or encourage people. Lunch was practical and lacked atmosphere. This is an area which could be improved to ensure that mealtimes were an enjoyable event. Additionally, the results of the 'resident' survey in 2016/17, indicated that some people also felt that improvement was needed.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence or the Alzheimer's Society) to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. This included falls teams, neurology nurses, dementia intensive support teams, GP's, podiatrists, opticians, and psychologists. We saw community nurses visiting during our inspection to see one person in the service. One person said, "The manager arranges everything. It's very good, [staff member] does my nails on a Monday and chiropody comes when they're needed." Another said, "The opticians came out and I've got more glasses."

Systems were in place to ensure that staff were provided with training and support, and the opportunity to

achieve qualifications relevant to their role. Staff had received training in medicines, safeguarding, first aid, MCA/DoLS, moving and handling and dementia. Refresher training had been booked in for 2018 to ensure all staff were up to date, and included other training opportunities, such as care of the dying and pressure area care. One staff member said, "Training is okay, had moving and handling training about a week ago. This was a good three hour practical session."

We also noted as an area of good practice, where one person living in the service had been sitting in on staff training sessions. The registered manager said they encouraged this, and told us the person was sent a certificate which was then put up in their room for everyone to see.

Staff new to the service completed an induction, which consisted of mandatory training and shadowing of more experienced staff. The registered manager told us that new staff would shadow experienced staff on several shifts, depending on their level of experience. If new staff did not hold relevant qualifications in care, they were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work

Staff received supervision sessions which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I get regular supervision with [registered manager], at least every two months."

Requires Improvement

Is the service caring?

Our findings

The provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture. During the inspection we observed some practices' that compromised people's privacy and dignity.

For example, during lunch time we saw a staff member standing over a person as they supported them to eat, rather than sitting with them at eye level. We also observed that two people's bedrooms were situated right onto the dining area. Both doors were open throughout the day, and anyone passing or sitting having their meal could see directly into the person's room. One person was receiving care in bed, and therefore could be watched by other people at all times. The registered manager told us this was so staff could see that the person was okay, but would consider rearranging the dining tables so the room was not directly in the line of people's vision.

Additionally, we found that none of the communal toilets or bathrooms had locks on them. There were signs on the doors saying, 'please knock before entering', however we found that this was not always observed. The provider told us that they did not think locks were permitted on doors, due to the need to get to people in emergencies. We explained that there are locks that can be opened from the outside in the case of an emergency, but which would allow people to have privacy when using the toilet or having a bath. They agreed to address this promptly.

The home had closed circuit television (CCTV) installed in the corridors and front entrance of the service. We asked people if they knew there was CCTV around the service. One person said, "Oh yes, the spy in the sky. Yes, that's okay; it means they [staff] can see what's going on." Another said, "Yes I did know. I'm easy with it." However, not all people were able to tell us their views due to living with dementia, and there was no reference to this within people's care plans. The provider told us that there were signs up outside the service relating to use of CCTV, however, they had not considered any implications this might have in relation to people's expectations of privacy. If any form of surveillance is used, providers must make sure this is in the best interests of people using the service.

All of the above constitutes a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We received mixed feedback about the approach of staff. One person said, "I get on with all of them [staff]. They know me. I'm on good terms with them [staff]." Another said, "Oh it's not too bad. There's one or two [staff] I don't get on with but I put up with them. You have to live here don't you?" A third said, "Most are okay."

Our observations during the inspection were that staff were kind and caring towards people. We observed a staff member hugging a person whilst singing to them. We also saw that staff were patient with people when they required assistance. The majority of staff had worked in the service for a long period of time, and knew people well.

'Resident' meetings were not held in the service as a way to hear people's views about their care on a regular basis. One person said, "The staff have meetings but we don't." Another said, "No, we [people] never have had meetings." Following the inspection, the registered manager informed us they were arranging a resident and relative meeting in the near future, and would be writing to families to inform them of this.

People's care plans were person centred and we could see that people had had input into creating them as their preferences were detailed. There was also an 'individual plan of care' which highlighted areas which were important to the person, and which gave a good overview of the person's needs. We saw that independence was encouraged, and reference to tasks the person was still able to do for themselves were noted. Some areas of the care plans stated; "Written after chatting with (person) and observing them during the day". This demonstrated that people had contributed to preparing their care plans.

Requires Improvement

Is the service responsive?

Our findings

Prior to our inspection, we received information that people were encouraged by staff to get up early in the morning as a means of helping the morning staff with their work. We asked people if they could choose what time they got up in the morning. One person said, "I get up in my own time." Another said, "I get myself up when I'm ready." When we arrived at the service at 7.30am, there were six people in the dining room waiting for breakfast, and staff told us this was their preference. The majority of people we spoke with told us they got up at their preferred time. However, one person told us, "Sometimes I can get up myself. They [staff] did get me up early; it was 6am the other day."

We spoke with a staff member who told us, "Some day staff get annoyed if night staff have not done as much as day staff would like before they come on shift, for example if not many people are up in the morning. Day staff particularly like those people who need two carer assistance to be up." They said this was not coming from the management team, but rather a few staff members. They went on to say, "Some people are wide awake when staff go round on the 4am check. If they are still awake at 5am staff ask if they would like to get up, but no one is forced to get up." We discussed the feedback with the registered manager and provider, who agreed to monitor the situation closely.

Staff told us they tried to be responsive to people's needs, but this was not always possible due to the staffing levels. For example, one staff member told us, "There was an incident recently at 10pm which delayed people being assisted to bed and some were not in bed until after midnight. The service expects night staff to do cleaning, veg preparation and laundry."

People's care plans included records of their food and fluid intake when there were risks. However, we found that for one person receiving care in bed, the form kept in their room for staff to complete covered various dates and tasks making it difficult to see whether the person had received adequate repositioning and fluids within a 24 hour period. The record did not specify how often the person should be repositioned or their continence requirements. Where records were kept in rooms, staff had not consistently documented each time they had checked on the person's welfare. Therefore records were not accurately or consistently completed to monitor people's progress. We also found in two care plans that not all areas of their care plan had been reviewed regularly. For example, one person was experiencing periods of agitation, but the care plan had not been updated to include guidance for staff on how to manage the behaviour to ensure they were supporting the person in the most effective way.

The approach to supporting people with their interests and to have meaningful and fulfilled days was not effective. There was an activity co-ordinator working in the service Monday to Friday for two hours per day. There was an activity schedule which included bingo, exercise, manicures, dominoes and cake decorating. We observed that there was little activity taking place in the service during our visit. The only organised activity we observed was several games of bingo for four people in the dining room before lunch.

We saw that when people did engage with staff they responded in a positive way, smiling and talking. However, in between these times people were sat for periods of time with no stimulation. Many people were

living with dementia and therefore required more time and attention from staff to ensure their social needs were met. However, staffing level arrangements were not sufficient to enable staff to provide dedicated time to activity. People told us they wanted more to do. One person said, "I just sit around. There's not too much going on." A relative said, "I don't think much goes on that [relative] would be able to join in with. I don't know if they [staff] spend any time trying to stimulate [relative]."

We could therefore not be assured that there was sufficient activity provision across the service to meet people's individual and specialist needs.

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some areas of good practice, for example, we saw that that Doll therapy had been introduced for two people living with dementia. Doll therapy is often used as an intervention which can help in reducing the behavioural and psychological symptoms of dementia. It can also provide a sense of role and purpose by taking care of the doll. We saw the two people chatting together about their dolls. This provided an opportunity for communication through interaction with the dolls, including tactile and sensory experiences. For example, one person spoke to us about what the doll was wearing, and how pretty the colour was.

The provider had not maximised the suitability of the premises for the benefit of people living with dementia. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

We recommend that the service explores current guidance from a reputable source, (such as the Social Care Institute for Excellence) in relation to improving the environment for the benefit of people living with dementia.

The majority of care plans we reviewed were detailed and person centred. These had been regularly updated by the registered manager. This included information on personal care, eating and drinking, mobility, continence, sleeping and resting, social interests, life history, and behaviour. Information was detailed, such as the sequence in which people liked to be assisted with their personal care. There were also 'pen pictures' which provided a quick reference guide to people's needs which staff or other professionals not familiar with a person could refer to. They listed people's likes and dislikes, their mobility, and key information about their care. There was also a 'consent to care' form which asked people how much involvement they wanted in creating their care plans, and how often they would like these to be reviewed.

The service had a complaints procedure for people, relatives and visitors to raise concerns. However, this was not displayed in the service so people knew who to contact if they had a concern, and we asked the registered manager to ensure this was made available. People did however tell us they would complain if needed. One person said, "I'd speak to [registered manager]." Another told us, "Yes I'd complain, I'm probably too outspoken at times." A relative said, "I would speak with the manager first." The service had not received any recent complaints.

Requires Improvement

Is the service well-led?

Our findings

Throughout the inspection the registered manager and provider demonstrated an open and transparent manner, actively seeking feedback to improve the service. Following the inspection the registered manager kept in contact with us to confirm that changes were already being implemented in response to our feedback, such as installing locks on bathroom doors, implementation of improved documentation, including repositioning charts, and closer analysis of falls data.

The registered manager had been in post since August 2015, and was previously the deputy manager within the service. They acknowledged there were areas where improvement was required, and recognised that their time had not always been used effectively to manage the service due to other demands placed on them.

Monitoring procedures did not effectively mitigate risks to people including their health, safety and welfare. For example, the service had an audit in place to monitor accidents and incidents which had occurred. However, the time at which people had fallen was not being analysed to identify themes and recurring trends thereby limiting future occurrences. Additionally we saw that for the month of September and October 2017, there had been an increase in falls between the hours of 6pm to midnight. However, the registered manager and provider had not used this information to consider how staff were deployed during these times or to increase staffing levels.

The auditing system in place had failed to identify all of the issues we found during the inspection; such as infection control. Audits and cleaning standards were not robust and had proved ineffective. They did not include how often to clean items, who was responsible, and what cleaning products should be used. This resulted in poor cleanliness across the service.

Additionally, environmental risks had not been identified. For example, in the downstairs communal bathroom, we found a cupboard which housed the main boiler system was not locked, and pipes were hot to the touch. We also found that wardrobes in people's bedrooms were unsteady and not secured to the wall. Both posed an accident and injury risk which had not been identified by the service.

We also found improvement was required in MCA, completion of documentation, staffing levels and activity provision. The provider and registered manager had failed to independently identify where improvement was needed, and their non-compliance with regulatory requirements.

All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other audits in place, such as monthly and quarterly nutritional audits, which enabled staff to identify weight loss effectively. An audit carried out on topical application, such as creams, had identified that staff needed to improve in this area, and ensure that they consistently signed records. The registered manager told us that this had started to improve; they had told staff and discussed concerns during

supervision.

Annual surveys were sent to staff, relatives and professionals as a way to gain feedback about the service. In 2016 we found the results of the various surveys were mainly positive. The responses were reviewed by the registered manager who made comments on each area of feedback they received, including actions to be taken as a result.

We observed the manager during the day spending time walking around the service and with people. On one occasion, they took time to talk quietly and gently to a person who was upset. It was clear they knew people well and took time to speak with them. People living in the service commented on the leadership in the service. One person said, "[Registered manager] is very good. I do see them around." Another said, "[Registered managers'] alright, she pops up sometimes."

Staff told us they were clear about their roles and responsibilities. One staff member told us, "Nice and friendly and very well run. The manager is really approachable, the owners are nice and like staff to have a laugh with the residents". Another said, "We have a good manager. We have regular team meetings. I sometimes think [registered manager's] hands are tied to a certain extent. Like having more staff. We [staff] mention it, but ultimately they need permission from higher up."

The provider had recently installed a new call bell system, and was planning to do call bell audits from this, which will show how long people are waiting for staff to respond. There were plans in place to convert one of the bathrooms into a wet room, decoration of the dining area and lounge, and were also planning to purchase handheld computer devices for people living in the service to use.

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 9 HSCA RA Regulations 2014 Person-centred care Activity provision was not sufficient to meet everyone's needs. The range of activities available were not always appropriate or stimulating for people living with dementia. Care records were not completed consistently to ensure assessed care needs were met. Some care plans had not been reviewed regularly. Regulation 9 (1) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Some practices' in the service did not uphold people's rights to privacy and dignity. 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Records did not reflect that care and treatment was being delivered in line with people's assessed needs. Risks to people were not mitigated as far as possible. Infection control procedures were not effective. Regulation 12 (1) (2) (b) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Auditing processes had been ineffective at identifying areas requiring improvement. Not all risks were being analysed sufficiently. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure that they were meeting people's needs at all times. 18 (1)