Springfield Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were clean and well maintained. Staff were appropriately vetted via Disclosure and Barring Service and other checks, prior to employment. All areas of the building including people's rooms, bathrooms and communal areas were clean, with infection control risks well managed and appropriately resourced.

The storage, administration and disposal of medicines was generally found to be safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). We found examples of good practice regarding the recording of medicine administration. We also found instances where medication audits had not successfully picked up on areas of inconsistency, particularly with regard to people's 'when required' medicines and we highlighted this to the registered manager and director.

Risks to people were managed through risk assessments and associated care plans. These risks were reviewed regularly and incorporated advice from healthcare professionals to keep people safe.

Staff displayed a good knowledge of safeguarding principles and indicators of abuse. They were clear what to do should they have any concerns. People we spoke with, their relatives and healthcare professionals consistently told us the service maintained people's safety.

Staff completed a range of training the registered provider considered mandatory, such as safeguarding, health and safety, moving and handling and dignity. Staff also completed training to equip them to support people's specific needs, for example British Sign Language training. Staff displayed a good knowledge of the subjects they had received training in and had a good knowledge of people's likes, dislikes and life histories.

Staff had built positive, trusting relationships with the people they cared for. Staff were well supported through regular supervision and appraisal processes as well as ad hoc support from management when required.

We saw people had choices at each meal as well as being offered alternatives. People spoke positively about the food they had and confirmed they could choose whether to eat with other people or in their room. We observed staff supporting people efficiently to eat and drink. We found the dining experience we observed to be functional but a missed opportunity to ensure people had a more positive, sociable experience.

The premises benefitted from some aspects of dementia-friendly design, although we found the ongoing refurbishment works had yet to have a significantly positive impact on people and, as yet, had not incorporated person-centred care into the design of communal areas. Person-centred care is about ensuring the person is at the centre of everything and their individual wishes and needs and choices are taken into account.

Likewise, whilst we found care planning documentation to be extensive, this did not always translate into person-centred care strategies, for example to distract and soothe people who may become anxious.

Group activities were varied and well planned, coordinated by a new member of staff with relevant experience. Improvements were planned to ensure people who could not choose to engage in group activities had alternative, meaningful options.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. We found some care planning documentation referred to capacity in blanket terms rather than in terms of capacity specific to individual decisions. The registered manager and director agreed to review this.

People who used the service, relatives and external stakeholders agreed that staff were caring and compassionate. We saw numerous instances of warm, inclusive interactions.

Person-centred care plans were in place and daily notes were accurate and contemporaneous. We saw regular reviews took place, ensuring people who used the service, relatives and healthcare professionals were involved.

The service had built and maintained good community links. Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and were positive about their approachability, responsiveness and knowledge of people who used 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?

Good

The service was safe.

Risks to people were assessed and relevant care plans were in place with instructions regarding how to reduce these risks. Input from relevant healthcare professionals was included in these care plans.

There were sufficient staff on duty to safely meet the needs of people who used the service.

There were effective systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Administration of medicines was safe and included examples of good practice, although the auditing of medicines had failed to identify areas of inconsistency.

Is the service effective?

Good

The service was effective.

A range of training the registered provider considered mandatory was in place, as well as additional training tailored to the needs of people who used the service, such as British Sign Language training.

The premises had undergone some recent refurbishment, which incorporated aspects of dementia-friendly design, such as clear signage and contrasting fixtures and fittings. The director had a plan in place to continue these refurbishment works.

People's nutritional and hydration needs were consistently met, although we found there was an opportunity to improve people's experiences at mealtimes.

Is the service caring?

Good

The service was caring.

People who used the service, relatives and external stakeholders agreed that staff were compassionate and patient. We observed

numerous interactions which supported these opinions.

People's religious beliefs and needs were respected, including people's preferences regarding the end of their life, which we found were respected and upheld.

Care plans were written with the involvement of people who used the service and their relatives to ensure they were partners in their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service held good levels of information regarding people's likes, dislikes and personal histories but had yet to fully incorporate this information into providing person-centred care.

Staff liaised promptly with external healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

Concerns were taken seriously and responded to consistently. People who used the service and their relatives were aware of who to complain to if they had concerns.

Is the service well-led?

Good

The service was well-led.

Quality assurance and auditing work was systematic and generally effective in addressing any inconsistencies and ensuring the registered manager and director and all staff were accountable for service provision.

People who used the service, relatives and staff were complimentary about the 'hands-on' approach of the registered manager and the director.

The service had built and maintained strong community links with a church and was attempting to build working relationships with other services in the area to share ideas of best practice.

Springfield Care Home Limited

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.

We visited the service on 18 and 19 May 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Adult Social Care Inspection Manager.

We spent time speaking to people and observing people in the communal areas of the home. We spoke with eight people who used the service and six relatives of people who used the service. We spoke with 11 members of staff: the director (who was also the nominated individual), the registered manager, the deputy manager, four care staff, the activities co-ordinator, the handyman, a domestic assistant and the cook. We spoke with a visiting nurse and a visiting GP. We looked at how people living with dementia were supported by using our Short Observational Framework for Inspection (SOFI) tool. We used this to help us see what people's experiences were when they were unable to speak with us.

Following the inspection we spoke with two social care professionals and one health care professional on the telephone.

During the inspection visit we looked at seven people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. No concerns were raised regarding the service by these

professionals.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service and their relatives confirmed they felt protected from harm. One person told us, "They put me at ease so I'm not anxious." Another person told us, "I always feel safe." There was a similar consensus of opinion from the external healthcare professionals we spoke with, with one stating, "I have never had any concerns in terms of people's safety – they are good at monitoring and managing falls or wounds," and another, "I've been visiting regularly for 30 years and haven't had concerns about people's safety."

There were sufficient staff on duty to meet the needs of people and we saw staffing levels were regularly calculated based on people's needs. People who used the service and their relatives confirmed they felt there were sufficient staff to meet people's needs, as did staff, including members of the night staff team we spoke with. We observed call bells being responded to promptly. One person told us, "It's never a case of having to wait – they always make sure you are okay whenever you need," whilst another said, "The staff make sure I'm well." This meant people using the service were not put at risk due to understaffing.

We saw risks were managed and reduced through an initial assessment then ongoing review, with the involvement of healthcare professionals where necessary. We saw appropriate help had been sought from external professionals where the risks people faced changed or increased, and that respective care plans had been updated to ensure staff knew how to mitigate the risks people faced.

Staff we spoke with had been trained in safeguarding and displayed a practical understanding of their safeguarding responsibilities. They described potential sources of risks, types of abuse what they would do should they have concerns. These responses were in line with the service's safeguarding policy, which was readily available in the entrance of the building.

We found examples of good medicines administration practice in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). For example, there was specific guidance in place for when people required a medicine presenting particular risks, such as alendronic acid. If alendronic acid is not administered correctly it can cause damage to the throat and stomach. We saw there was clear guidance for staff regarding safe administration and potential side effects.

We saw medicines were stored securely and kept in separate locked trolleys for each floor, in a locked room where the temperature and fridge temperature were regularly checked to ensure they were within an appropriate range. We saw people's profiles contained a photograph, allergy information, GP practice contact details and personal preferences regarding how the person liked to take their medicine. We saw the medication file contained staff signature sheets, which made it easy to identify who had administered medicines, as well as a sheet documenting what time the medicine administration began and finished. This meant there was an accurate record should there be any queries about a person's medication history.

We found there was scope to improve the consistency of medicine administration documentation. For example, we found some instances of good practice regarding people's individual care plans regarding

'when required' medicine. One plan, for example, stated, "[Person] would write in the book if they were in pain," to help staff identify when a person who could not verbally communicate may need paracetamol. Not all 'when required' medicine was supported by such specific guidance. For example, one plan was much less specific about paracetamol, stating, "To assist with agitation." We also found instances of people's 'when required' medicines not being accompanied by any guidance, for instance for a laxative. NICE guidance on this subject, 'Managing Medicines in Care Homes,' March 2014 (1.14.2) states that there should be a process in place for each 'when required' medicine, including the reasons for giving 'when required' medicines and the expected outcomes. This meant staff did not always have sufficient person-centred information to be able to effectively administer people's 'when required' medicines.

We saw medicines audits had taken place but they had not proved effective in identifying these areas of inconsistency. The director and registered manager committed to reviewing their auditing procedures and to rectify the inconsistencies highlighted during the inspection.

We observed people who displayed signs of anxiety were supported by staff who either listened to their concerns or employed methods of gentle distraction, as per relevant care plans. These plans gave instructions to staff on how people may display their anxiety and what to do to soothe them, although we found these plans would have benefitted from more person-centred details. This is discussed further in the Responsive key question.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service checks had been made. The Disclosure and Barring Service maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We also saw the registered manager had asked for at least two references, verified these references and ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a robust and consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

People who used the service and their relatives commented on the cleanliness of the service and we noted it was generally clean. One person said, "It's always lovely and clean." We noted a carpeted area on the first floor of the home was showing signs of wear and gave off an odour. The registered manager and director confirmed replacing the carpet was part of the refurbishment plan. We saw a copy of this plan, which confirmed this and other works. One external professional told us, "There is a low incidence of infection and it's always clean when I visit." This meant people were protected against the risk of infections.

We spoke to the handyman, who was responsible for the general maintenance of the premises. They had a systematic approach and other members of staff used a maintenance file to log any concerns about the fabric of the building. The handyman told us they received all necessary equipment from the registered provider and we found the building to be generally in a good state of repair. Additionally, we saw Portable Appliance Testing (PAT) had been undertaken, whilst all hoisting equipment and lifts had been serviced. We saw emergency systems such as the call bell system and emergency lighting were tested regularly, fire extinguishers/equipment had been serviced and window restrictors regularly checked. We saw water temperature checks had been undertaken regularly to protect against the risk of burns. Shower heads were regularly disinfected and descaled to protect against the risk of water-borne infections. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were acted on and documented in a manner that allowed for easy analysis to identify any trends and patterns and saw that such analysis happened regularly.

With regard to potential emergencies, we saw there were easily accessible personalised emergency evacuation plans (PEEPs), detailing people's mobility and communicative needs, as well as floor plans. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

People who used the service, relatives and external professionals were complimentary about the level of staff knowledge and experience. One professional told us, "They always follow the plans we put in place and they are good at meeting people's needs," whilst another said, "They know people well."

We found people who used the service received effective care from staff who had a range of knowledge and skills. We saw new staff underwent an induction process that included completion of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. We saw the registered manager had also planned for existing members of staff to complete modules from the Care Certificate to refresh and enhance their current knowledge. We found training needs to be effectively monitored and refreshed via a training matrix.

We saw staff had been trained in a range of subjects, such as safeguarding, moving and handling, first aid, fire safety, dementia awareness, infection control, mental capacity, medicines administration, end of life care and dignity in care. We also saw staff had been trained in order to meet the specific needs of people who used the service. For example, staff had been trained in Parkinson's Syndrome awareness, whilst three staff members were currently being trained to use British Sign Language (BSL) in order that they could better communicate with a person who used the service who was deaf. Staff we spoke with relished the opportunity to learn this new skill and we observed a member of staff utilising these skills during the inspection. This demonstrated the registered manager had ensured people's needs were met through the provision of relevant training.

One external professional told us, "In terms of hydration and nutrition they meet people's needs." We spoke with a carer who displayed a good knowledge of one person's nutritional and hydration needs and explained how they monitored these needs to ensure the person received the appropriate sustenance. We saw people were regularly weighed to protect against the risk of malnutrition and we saw the director planned to train staff to use the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition.

We spoke with the cook who displayed a good knowledge of the specialised diets required by people who used the service, for example, soft diets, fortified diets and diets for people with diabetes. We saw corresponding information was on display on the kitchen wall and, when we reviewed care plans, saw advice from the Speech and Language Therapy (SALT) team had been incorporated into people's meal planning.

People who used the service told us they enjoyed the food and had a range of choices at each meal. They told us if they didn't like one of the options the cook would prepare something else and we saw instances of this on both days of the inspection. We observed people being offered drinks and snacks throughout the day via a tea trolley. One person told us, "I always have a big breakfast and an extra bowl of porridge."

With regard to the dining experience, we conducted our SOFI observation during lunch on the first floor. We

found interactions from staff to be patient and functional, with people receiving help to eat where it was required. We found the majority of interactions between staff and people who used the service to be neutral rather than markedly positive or encouraging, although we noted this did happen at times and that people were spoken to politely and had their nutritional needs met.

We found more could have been made of the dining experience and also saw menus had not been adapted, for instance with pictures or large font, for people with impaired vision. The registered manager agreed to review this with a view to improving people's mealtime experiences.

We reviewed the content of care files and saw the advice from health and social care professionals had been incorporated into in people's care, for example from community matrons and GPs. We saw people were supported to access primary health care, such as GP visits and dentist appointments, along with secondary health care such as chiropody. We saw evidence of people experiencing good quality of life outcomes. For example, one visiting professional told us about one person with a range of health complications, who they described as now, "Thriving," in the environment.

We saw the registered provider had made alterations to the premises to meet the needs of people. For instance, the spouse of a person who used the service was due to move into the home. The registered manager ensured the couple were able to share a larger room and converted one of the bedrooms into a lounge area for them. The person we spoke with and their family confirmed they were extremely pleased with the arrangement and stated, "I'm not anxious anymore – it takes the pressure off my heart." This demonstrated the provider had regard to people's individual needs and preferences when altering the premises.

We found a number of instances of good practice in the design of the building. For example, where refurbishments had taken place we saw walls contrasted well with floors and hand rails, signage was clear and with braille content, whilst lighting was bright and fittings in bathrooms were well contrasted. The registered manager told us the design of the environment had regard to research by the University of Stirling on dementia-friendly design. We noted the alterations were in line with guidance by the Department of Health ('Dementia-friendly Health and Social Care Environments,' March 2015). During our inspection the director of the service was consulting people who used the service on their preference for the colour of curtains.

We saw a number of staff had been enrolled on NVQ courses to further their knowledge and all staff we spoke with told us they were well supported to deliver care through the training, guidance and supervision they received. Staff confirmed they received regular supervision and appraisal meetings and we saw evidence of this in personnel files. Similarly, we saw evidence of regular staff meetings and, where staff could not attend, they confirmed the registered manager shared the minutes of these meetings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS. We noted in some care files there were some blanket references to people's capacity, rather than statements regarding their capacity regarding specific decisions. The registered manager agreed they would review the terminology used in care files regarding people's capacity to make decisions.

Of the seven care files we reviewed, two contained Do Not Attempt Cardiopulmonary Respiration (DNACPR) forms that had not been completed appropriately. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. We found on one form the reason for not attempting resuscitation was not specific enough, merely stating, "Advanced age with dementia." On another form we saw a handwritten note stating, "To discuss with next of kin." We saw later in the person's care file they had capacity to make a range of decisions and that they were not in touch with their next of kin. This meant information pertaining to the actions that may or may not be taken should people suffer a heart attack were not sufficiently detailed, robust or in line with the principles of the MCA. We alerted the registered manager to the issue, who contacted the clinicians who had completed the forms immediately and also requested advice from the local safeguarding team.

Good

Is the service caring?

Our findings

When we asked one person who used the service about the staff, they told us, "They are absolutely lovely." Another person said, "They're always very, very nice." Relatives told us, "The staff are really good," whilst visiting professionals told us they were always welcomed and that, "Staff are always polite with people and patient with them."

Through our observations we saw staff taking time to ask people how they were and to patiently wait for a response. We saw staff giving people a range of options and waiting for them to choose. We sat with one person who used the service in a communal area and noted that members of the kitchen and domestic staff regularly stopped to chat with this person and knew about their interests. We saw staff engaging in humorous interactions with people who used the service where appropriate. This demonstrated the meaningful bond that staff had made with people who used the service.

We observed numerous instances of staff interacting sensitively and discreetly with people who used the service in a manner that upheld their dignity. For example, when people required help with personal care we saw staff discreetly support them away from a communal space in order that their needs could be met in a dignified manner.

A range of thank-you cards presented further evidence of the caring attitudes of staff. Representative comments included, "I was very happy with my [Relative's] care and treatment – they are extremely happy," "A massive thank you for all the loving care," and, "Many thanks for your care and attention." This demonstrated the director and registered manager had successfully had ensured the culture at the home was one of genuinely caring about people's wellbeing.

Where relatives raised concerns about other aspects of the service such as levels of communication, they clarified that they did not have concerns about staff attitudes, stating, "The care side is excellent."

We saw the service had recently appointed a dignity champion. This person's role would be to attend team meetings, undertake observations and assist with training, although at the time of the inspection they had yet to begin their role. We saw clearly displayed in the service the National Dignity Council's '10 Dignity Do's,' which are a set of behavioural standards staff and others can have regard to when interacting with people who use the service.

One healthcare professional told us they were welcome at any time and numerous relatives confirmed they had visited at a range of times and always felt welcome. One told us, "It feels homely." This further demonstrated people who used the service were made to feel more at home through ensuring visiting hours were not restricted.

We noted the turnover of staff was low. One relative and one visiting professional stated they thought this was important to ensure people received a level of continuity and familiarity in their care and we found all staff we spoke with had a good knowledge of the people they cared for. When we reviewed care plans we

found them to contain good levels of information regarding people's preferences and wishes. We saw people had consented to their care plans and, where they lacked capacity to consent to the care given, we saw family members had been involved.

We noted one phrase used in a medicines administration document that was no longer appropriate in the social care profession. When we highlighted this to the registered manager they took immediate action. We found this to be an isolated use of terminology and that staff treated people respectfully.

We saw that people's religious beliefs were respected and upheld. For example, the home held a church service monthly in the home for people who wished to attend. We also saw in one person's room information reminding staff that their religious beliefs precluded conversations about gambling or alcohol. This demonstrated the registered manager ensured people's diverse beliefs could be respected in a practical way.

We saw people who were unable to make their own decisions were provided with natural advocates through the service's involvement of family members in decision making.

We saw people were encouraged and supported to celebrate relationships and milestones. For example, we saw a sixtieth wedding anniversary party had been arranged for two people who used the service, with relatives and friends due to attend. We also saw evidence of the registered manager and director sending flowers to people who used the service on their anniversary and arranging a birthday cake.

External professionals we spoke with were complimentary about the ability of staff to sensitively support people at the end of their lives, citing good relationships with district nurses and Macmillan nurses. We saw detailed end of life care plans in people care plans. We spoke with one relative during our inspection regarding the care their relative had received at the service. We saw the wake was being held at the service and the relative we spoke with told us they felt it was important to reflect on the positive relationships staff had built with their relative. They told us, "It's a caring culture. They don't tolerate people who don't care."

We saw people's personal sensitive information was securely stored in locked cabinets, in line with the confidentiality policy.

Requires Improvement

Is the service responsive?

Our findings

We found care files contained a good amount of information specific to individuals, including their likes, dislikes, hobbies, personal histories and people and places that were important to them.

We found this information had not always been fully incorporated into people's care to ensure person-centred care was delivered consistently. For example, we saw one person required staff to use distraction techniques when they became anxious. We observed staff attend to the person's needs throughout our inspection but did not observe any staff incorporate aspects of that person-centred information that could have improved the person's experiences. For example, the person's care file had detailed notes about where they had grown up and what sporting and recreational activities they valued. When we reviewed the relevant behavioural care plan we saw none of this had been factored in to how to distract the person and soothe potential anxieties. We found these plans to be limited to more general instructions such as, "Staff to ask [Person] what they would like to do. Offer a hot drink and snack and give reassurance." The Alzheimer's Society guidance document, 'Dementia and Aggressive behaviour,' highlights the importance and effectiveness of staff incorporating, "What they know about the person, including their personality, likes and dislikes," into distraction strategies.

We found examples of other missed opportunities to translate people's personal likes, dislikes and histories into person-centred care. For example, whilst one area of the first floor had been redecorated and incorporated aspects of dementia friendly design, there were no person-specific additions or alterations. We reviewed a dementia audit undertaken by the registered manager which stated the environment was "object rich" and that there were, "Accessible activities and there are opportunities for activity or engagement within each communal room." The comments section went on to state, "Sensory room located on first floor for all to use." We spoke with two members of staff who confirmed this room was not used. We noted the corridors had been decorated with a range of film posters and one room, known as the 'library' had book-themed wall paper, but there were no books on the shelves and no communal items of interest that people could engage with, such as rummage boxes or artefacts that may have been of interest. The Department of Health guidance document, 'Dementia-friendly Health and Social Care Environments' (March 2015) gives a range of examples of how memory boxes, memorabilia and rummage boxes can enhance people's involvement and meaningful inclusion in their environment.

This demonstrated that the service had yet to establish the model of person-centred care the service's literature aspired to. We spoke with the registered manager and director about this issue and they committed to ensuring communal spaces and care planning would be more person-centred. After the inspection the registered manager stated they were overseeing work to make care plans, "More person-centred and unique to the individual," and would drive improvements in this area via a formal action plan.

Care files were generally well-ordered and easy to follow for care staff and visiting professionals. We saw care plans were reviewed regularly and people confirmed to us they were involved in the review process.

We spoke with the activities co-ordinator, who had only been employed at the service for two weeks. In that

time we saw they had held a residents meeting to establish what activities were popular and what activities may prove popular in the future. We saw there were card-making sessions planned in response to feedback from this meeting, along with a range of optional group activities. People who used the service we spoke with told us they enjoyed the activities offered, for example armchair exercises, film afternoons, hand massages and bingo. Relatives also told us people enjoyed these activities, stating, "There's plenty to do," and, "They do outings and the option is there to get involved." We saw a range of group activities being delivered during the inspection and observed people responding positively to these activities. We also saw the on-site hair salon was used weekly.

The activities co-ordinator acknowledged they had not yet had an opportunity to review people's individual likes, dislikes and personal histories to ensure that the range of activities had regard to ensuring people who were unable to communicate their wishes were also supported. They stated it was a priority of theirs to spend more time with people on the first floor who were unable to choose to take part in group activities, for example through one-to-one time. We found the activities coordinator to have a good knowledge of how to identify meaningful person-centred activities but had yet to put this into practice at the service. The registered manager, who was due to take on the role of Dementia Champion for the service, committed to ensuring the activities co-ordinator would be supported to gather this person-specific information in order to inform their activity planning.

We saw people's health needs were responded to promptly and with the ongoing involvement of a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. Professionals we spoke with were complimentary about the levels of responsiveness displayed by staff. One healthcare professional told us, "I'm here regularly but if they come across anything in the interim they get in touch. They ring me before 10am if there are any specific concerns." Another told us, "They notice changes in conditions very quickly and if we give them a plan, they follow it." We saw emergency health care plans were in place detailing people's medical, mobility and communicative needs to better inform healthcare professionals, should a person need to receive emergency treatment outside the home.

The majority of relatives we spoke with were similarly positive about the ability of individual staff and the director and registered manager when talking about how they felt involved in the reviewing of care planning. One relative told us, "They were brilliant and kept us informed at every stage."

We saw surveys were used as a means of routinely gathering more information from relatives, people who used the service, staff and professionals. We saw all surveys were returned with an average response rate of 50% and that all responses were positive regarding standards of care and the responsiveness of staff.

We noted in one instance that one person's care planning had not been accurately updated or reviewed to reflect the fact their circumstances had changed. The registered manager and director acknowledged communication with the person's family in this case should have been better and that the person's changing circumstances should have been appropriately documented. The registered manager reviewed the service's policies and procedures, confirmed there was a relevant procedure in place for this eventuality, but that it had not been followed in this case. They committed to ensuring the policy would be adhered to closely in future.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas, as was the suggestions box. People we spoke with and their relatives knew how to make a complaint and who to approach, as per the registered provider's policy. The registered manager told us they had received no complaints in the past year. When we reviewed correspondence we found a number of concerns lodged by a family member that, whilst comprehensively responded to by the registered manager,

satisfied the criteria set out in the complaints policy. Had these concerns been recorded as complaints they would have been subject to the analysis the complaint procedure involved. The registered manager and director agreed to review their application of the complaints policy to ensure the concerns people raised were more consistently recorded.

Good

Is the service well-led?

Our findings

The registered manager had relevant experience in health and social care and a sound knowledge of the day-to-day workings of the service. They had been in post as registered manager since October 2013 and had relevant experience of dementia mapping. Dementia Care Mapping is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence (NICE). As discussed in the Responsive key question, person-centred care had yet to be fully achieved at the service, and this was an area the registered manager committed to focus on, both through their own application and through supporting other staff to achieve this outcome.

Members of staff we spoke with told us they had confidence in the registered manager and director and that they had ensured the culture at the service was a caring one. We found this to be supported by the conversations we had with people who used the service, their relatives and through our observations.

One person who used the service told us, "Yes, I know the manager, they're nice," whilst relatives told us, "They really get to know [Person], which I don't think is always the case in bigger homes," and, "They have an open door policy and it always feels homely." We observed the registered manager and the director regularly engaging with people who used the service to meet their needs. The registered manager displayed a good knowledge of people's needs and preferences.

Staff we spoke with were extremely positive about the level of support they received from management, in terms of formal training but also the 'hands-on' approach the registered manager and director took. For example, one member of staff told us about how the director had recently completed a nightshift to ensure they understood all aspects of the role. The director also had an extensive background in personal care and a good knowledge of people who used the service. Staff told us, "They are both very supportive," and, "Management are always there when you need."

External professionals we spoke with all confirmed they had positive working relationships with the management at the home, with one stating, "It's well managed and well staffed."

With regard to establishing aspects of best practice, we found the registered manager and director had begun to do this, although acknowledged they had more work to do. For example, they were able to demonstrate that aspects of best practice with regard to dementia friendly design had been incorporated into recent refurbishment work, although this had not yet been coupled with adhering to best practice regarding person-centred care.

We saw the registered manager had written to local care home managers to invite them to a coffee afternoon with a view to sharing best practice and to increase opportunities for mutually beneficial working relationships. We saw good relationships had been formed with a local church, who held a monthly service in the home for people who used the service and visitors to attend.

We also saw the registered manager had introduced a range of champions, specifically: dementia, safeguarding, medication, infection control and dignity. These roles had yet to be fully implemented but the registered manager was able to explain how they would complement existing staff meetings and auditing systems.

With regard to auditing, aside from some improvements to be made with regard to the medicine and dementia audits, we saw there was a high degree of accountability through the systematic auditing of all aspects of the service, including care plans, facilities and health and safety. We saw evidence of these audits highlighting areas for improvement and ensuring corrective action was taken within specific timeframes, for example where a care plan had not been updated with a new communication plan. We saw sufficient time and resource was dedicated to auditing, with 8 hours supernumerary time each week set aside for this purpose. We noted auditing documents still referenced previous CQC regulations. The director undertook to update these documents in line with current (2014) regulations.

We saw staff had supported charities such as the Alzheimer's Society, as well as raising funds to contribute to activities provisioning, by completing sponsored events such as bike rides and walks.

The registered manager told us they were hoping to achieve International Organisation for Standardisation 9001(ISO) accreditation as well as Investors in People accreditation. ISO is an internationally recognised certification of an organisation's consistency of policy. Investors in People is an internationally recognised certification of an organisation's ability to sustainably lead, support and manager people.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided and we found the registered manager had ensured records regarding people's person care were accurate and up to date.