Barchester Healthcare Homes Limited

Hugh Myddelton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 29 and 30 September and 2 October 2016 and was unannounced. Our inspection was brought forward because we had received concerns relating to staffing levels and the high number of safeguarding alerts raised with the local authority by health and social care professionals.

During the last inspection on 10 May 2016, we found the home was in breach of two legal requirements and regulations associated with the Health and Social Care Act 2008. We found that people who used the service were not always protected with the risks associated with their care and there were deficiencies in relation to the monitoring of people's hydration and nutrition.

Hugh Myddelton House is registered to provide nursing care and accommodation for a maximum of 48 adults, some of whom live with dementia. At the time of our inspection, there were 46 people living in the home. The home covers three floors. On the ground floor there is capacity for 19 elderly frail people. On the first floor there is capacity for 19 people living with dementia and on the second floor there is capacity for ten younger people with disabilities.

A general manager commenced employment at the home at the end of June 2016. The general manager has applied for registration with the Care Quality Commission. 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. A deputy manager had also been recruited since we last inspected the service.

There were insufficient numbers of staff on duty at all times to meet people's needs. Whilst staffing levels had been determined using a recognised tool, we identified errors had been made in using the tool. We received consistent feedback from people, relatives and staff that staff levels were a cause for concern. From our observations, care often appeared to be task focused and, on a number of occasions, people were either left in bed or wheelchairs for extended periods of time. There was an activities programme in place, although many people remained in their bedrooms and were not always supported to access communal areas or engage in activities as staff were engaged with care tasks. Staffing levels also did not reflect the rotas in place at the time of the inspection.

Medicines were being managed safely.

People, relatives and staff spoke positively of the current management team. Quality assurance processes were in place to monitor the quality of care delivered. However, learning from incidents of home acquired pressure ulcers was not evident and the service did not follow pressure ulcer prevention best practice.

People told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. All staff had completed training in safeguarding adults and demonstrated an

understanding of types of abuse to look out for and how to raise safeguarding concerns.

Detailed current risk assessments were in place for all people using the service. Risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

Appropriate checks had been made to ensure the premises was safe.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff had regular supervisions and annual appraisals; however the general manager told us they were behind with annual appraisals. Staff were safely recruited with necessary pre-employment checks carried out.

People were given choices during meal times and their needs and preferences were taken into account. Nutritional assessments were in place for most people, which included the type of food people liked and disliked. People's weight were recorded regularly and action was taken should people were to lose or gain weight significantly.

All staff had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and staff understood what to do if they had concerns as regards people's mental capacity. These safeguards are there to make sure that people are receiving support are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

We observed caring and friendly interactions between management, staff and people who used the service and people spoke positively of staff and management. However, we observed people were left unattended for periods of time in communal areas as staff were deployed elsewhere assisting people.

Referrals had been made to other healthcare professionals to ensure people's health was maintained.

A complaints procedure in place which was displayed for people and relatives. There was an incident and accident procedure in place which staff knew and understood.

Staff, residents and relatives meetings were held regularly and surveys were completed by people and relatives.

People, relatives and staff spoke positively of the current management team. Quality assurance processes were in place to monitor the quality of care delivered.

We identified a breach of regulations relating to safe staffing levels. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. Staffing levels did not reflect the levels of dependency of people who use the service and there were regular staff shortages.

Medicines were managed safely.

People told us they felt safe. Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles.

Is the service effective?

Good

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

Mental capacity and Deprivation of Liberty safeguards were understood and principles of the code of practice were being followed.

People were given the assistance they required to access healthcare services and maintain good health.

People told us they enjoyed the food on offer. We saw meals were fresh and looked and smelled appetising.

Is the service caring?

Good

The service was caring. There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding on people's background and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service employed activity co-ordinators who arranged activities for the people; however care staff were not always able to assist with supporting people to attend activities.

People were left unattended in communal areas for periods of time.

The home had a complaints policy in place and relatives knew how to complain if they needed to.

Is the service well-led?

Good

The service was well led. The quality of the service was monitored.

People, relatives and staff spoke positively of the general manager and the management structure.

Hugh Myddelton House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on Thursday 29, Friday 30 September and Sunday 2 October 2016. The first and third days of the inspection were unannounced.

Our inspection was brought forward because we had received concerns relating to staffing levels and the high number of safeguarding alerts raised with the local authority by health and social care professionals.

This inspection was carried out by three adult social care inspectors, a pharmacist inspector and a specialist advisor in the prevention and management of pressure ulcers. The inspection team was also supported by 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.

During the inspection we spoke with 23 people who used the service, 14 relatives, the home manager, the deputy manager, the regional director, four registered nurses, seven carers, the activities co-ordinator and two healthcare professionals visiting the home on the day. We spoke with one healthcare professional via telephone during the inspection. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We looked at 10 people's care files and risk assessments, daily recording records, nine staff files, staffing rotas and records relating to the management of the service.

Prior to the inspection we received feedback from the local authority safeguarding team, Healthwatch and the Care Home Assessment Team (CHAT).

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 10 May 2016, the home was in breach of regulation 12 associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that risks to people who used the service had not been appropriately assessed and risk assessments had not been reviewed on a regular basis. The provider sent us an action plan telling us how they would ensure this was addressed. At this inspection, we found that the provider had addressed these issues.

During this inspection we saw evidence that risk had been adequately assessed for people using the service. A nurse told us, "We complete risk assessments in the first six hours of their admission. We take photographs with their consent. We complete risk assessments for bed rails, bumpers and dementia. Staff should know how to approach a person." Staff were able to explain how they would work with people's identified risks. Risk assessments were up to date and reviewed monthly. Risk assessments covered risks to people such as skin integrity, moving and handling, falls, risks associated with the use of bedrails and choking. Training records showed that all staff had completed training in choking and Dysphagia.

Skin integrity was assessed using Waterlow charts to determine risk levels. During our last inspection we found that Waterlow risk assessments were not always reviewed on a regular basis for people assessed as high risk for developing pressure ulcers. During this inspection we found that Waterlow charts were reviewed and updated on a monthly basis and Waterlow scores had been correctly calculated.

The provider has been recognised for their pressure ulcer prevention work called 'Mi Skin matters'. This has been advertised on the NHS care home stop the pressure website as gold standard practice. This includes documentation on checking the skin and using a measurement tool called 'the safety cross'. This was contained within the home's wound care folder but staff we spoke to within the home were not aware of this best practice. Where pressure ulcers had been acquired in the home, no root cause analysis was conducted and staff not routinely invited to reflect or contribute to the agreed set actions. This would contribute to collective learning for all staff.

During our last inspection on 10 May 2016, we received comments from people regarding call bell response times, especially at night. We were unable to investigate as call bell response times were unavailable to view. At this inspection, we received mixed comments from people regarding call bell response times. One person told us, "Girls are very good. Always someone available." Whereas another person told us, "Most of the staff are alright, a few are difficult. They get very tired and they get impatient. I have to wait a long time when I pressed the buzzer but most staff show respect." Call bell response times were printed on a daily basis and response times were analysed with delayed response times followed up and investigated. Call bell maintenance records were also documented. Records confirmed that call bells were responded to in a timely manner and where there had been delays noted, this was investigated. Call bell response times also formed part of staff supervision sessions.

We spent time looking at the staffing arrangements in place to support people living at Hugh Myddelton House. We spoke with people who used the service, relatives, and staff, looked at staffing rotas, the

dependency tool and observed the support offered throughout the day.

Most people, relatives and staff we spoke with told us they had concerns in relation to staffing levels at the home. Prior to the inspection, we received feedback from healthcare professionals involved with the service who also raised concerns around staffing levels at the home, particularly on the second floor. One person told us, "They take a lot of time to do something for me. When I wanted to go the loo they took their time by then I messed myself. I have to ask them to support me with personal care." Other comments from people included, "Staff do very well, but they are always rushing when there are less staff, sometimes there are no staff to ask for support"; "There are not enough carers. The whole lot go at 8pm"; "The staff are too busy" and "Before it was better. Now there is just one carer after 3pm." One person told us that they called a relative on their mobile phone to request assistance when the call bell had fallen out of reach.

Comments from relatives included, "This is the best place for [relative] to receive support, he had falls at home, admitted to hospital and could not go back home. The management do very well with the staff they have but they have less staff. The staff are always rushing, sometimes no staff to ask if there is any accidents"; "Staffing levels are down again. I didn't notice before but sometimes in the afternoon there is nobody around. Staff are very good but it's dangerous. I know that if they need help to hoist, they have to borrow staff from another floor" and "The carers try to sit down and talk to people but they just don't have enough time." People and their relatives were also clear that despite feeling there were not sufficient staff; they felt that staff were caring and trying to do their best.

We discussed staffing levels with staff and how this impacted on people who use the service. One member of staff told us, "I love my home. I deal with people's lives. It's not just a job. Sometimes we don't have time to have a rest. I will fight for my residents like a lion." Another member of staff told us, "It is difficult and impacts on care. Most people are heavy weighted and the nurse can be involved but not always as other jobs to do. Sometimes people have to wait. We call on other floors to help but now they are short as well. The impact on care is that people wait longer to be changed which can damage skin. The relatives are not happy and at times there has been verbal abuse. Staff feel unsafe and intimidated. It's not a good feeling." Another member of staff told us, "There is no time for activities, we talk to them but we can't sit with them." Other staff also told us that it was the preference of one person who used the service to have a shower in the afternoon due to sleeping patterns. However, staff were often unable to comply with this request as there was insufficient staff in the afternoon to allow two staff members to support the person to have a shower.

We discussed the care needs the people on the second floor had with staff and established that nine people were fully dependent on staff for care therefore required two staff to assist with moving and handling. Staff told us that the afternoons were quite busy as after lunch people often needed assistance with personal care or wished to go to bed. This meant that two staff would be required to assist with moving and handling on a number of occasions in the afternoon. On one afternoon during the inspection, the nurse on the second floor was required to sign in and check a delivery of medicines which meant that the carer on the second floor had to request assistance from other floors when people requested assistance which required two members of staff. We also observed that when both staff on duty were assisting people in their rooms, the floor was left unattended and people who remained in communal areas were left unsupervised.

From our observations, we found that staff support throughout the home was centred on care tasks, with little opportunity to spend time with people. Those people who spent their time quietly or sleeping were left unless they needed care or it was mealtime, which was reflected in comments we received from people, relatives and staff.

We discussed the home's capacity and staffing with the general manager and regional director. On the first

day of the inspection there were 44 people using the service. On the second day of the inspection this had increased to 46 people. The ground floor which caters for elderly frail people has 19 beds. The first floor which, which is called 'Memory Lane' caters for people living with dementia, and has 19 beds. The second floor which caters for younger people with disabilities has 10 beds. The general manager told us that they have one vacancy for a night nurse. The general manager told us that they rarely use agency staff and use a nursing bank to fill gaps in the rota.

The provider used a Dependency Indicator Care Equation (DICE) tool to assess dependency levels and calculate staffing levels. The DICE is a tool that takes into account the person's needs and level of support and then calculates how many hours of support the person requires. The initial assessment was carried out by the manager or senior nurse and then reviewed monthly. The DICE tool also takes account national averages of peoples assessed needs against the hours recommended by the tool. According to the tool the home is overstaffed by approximately 18 hours per day. However, we found two instances of where people's care needs had been incorrectly assessed on the DICE tool. In one example, a person's mobility had been assessed as medium which meant that they could bear their own weight. However, this person was unable to bear weight and required two staff to assist with moving and handling which should have resulted in an assessment of high. Another person's continence had been assessed as low on the DICE tool but the person's care plan stated that they were prone to urinary tract infections and constipation which should have been assessed as medium as per the DICE assessment criteria. This was discussed with the general manager who amended the DICE tool accordingly.

The general manager and regional director told us that there was one nurse on duty on each floor all day. On the ground and first floors, there were four carers on duty until 2pm and afterwards three carers until 8pm. On the second floor, there were two carers on duty until 2pm and afterwards one carer until 8pm. At night, there was one nurse and two carers on duty on the ground floor and one nurse and two carers on duty to provide cover on both the first and second floors. The regional director told us that if staff on the second floor required assistance in the afternoons, staff would be deployed from other floors to assist as and when needed.

Staffing levels did not reflect the rota in place at the time of the inspection. For example, on Wednesday 28 September 2016, the ground floor had one nurse and three carers on duty all day with one carer on escort duty. On the first floor there was one nurse and three carers on duty all day. On Saturday 1 October 2016, the staff duty form which staff completed showed that there was one nurse and three carers on duty on the ground floor all day, one nurse and two carers on duty on the first floor all day and one nurse and one carer on duty on the second floor all day. On the night of Saturday 1 October 2016, two nurse and three carers were on duty as opposed to two nurses and four carers. We discussed this with the general manager who told us that staff had called in sick on that day. A member of staff told us that on that day a carer had to be asked to by colleagues remain after their shift finished to assist colleagues. The provider had failed to ensure that staff levels adhered to the provider's own needs assessment and rota. This meant that people were placed at risk of receiving unsafe and ineffective care.

The above is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed. One person told us, "They are very prompt with the medicines and they don't leave until I take my medicines." Nurses were trained and assessed as competent to administer medicines. A nurse who had recently started working at the service described how she had shadowed more experienced nurses before being able to do the medicines alone. We saw people being given their medicines in a safe and caring manner. Some people were prescribed medicines to be given at

specific times. Nurses described to us how they made sure this happened. One person told us that they had a clock and liked to check that they had their medicines at the correct time and they were happy with how this was managed. Care workers applied people's creams and topical medicines when they supported them with their personal care. They recorded these on a chart which had clear instructions for use.

Some people needed blood tests to monitor their medicines, we saw that these were done and doses adjusted when necessary. There were clear guidelines available for staff to follow if people were prescribed fluid thickeners. These were kept safely and care staff we spoke with were clear as to how to make up people's drinks. People who were able to and wished to do so were supported to manage their medicines themselves. People who were in the home for respite periods particularly benefited from this as their independence was maintained. We saw that staff reviewed this regularly to keep people safe.

Medicines were stored securely and appropriately including controlled drugs and medicines requiring refrigeration. Staff did audits on each unit to check that medicines were being managed safely and we saw that where discrepancies were noted, actions were taken and recorded.

We saw that medication administration records (MAR) were clear and had been completed accurately showing that people received their medicines as prescribed. Some people were prescribed medicines to be taken 'when required'. We noted that the MAR for these showed regular codes of 'not required' rather than signing for the medicine only when it was used and noting the time.

People told us they felt safe living at the service. One person told us "The girls [staff] are very fantastic, I feel safe." Relatives also told us that they felt their loved ones were safe living at the service. One relative told us, "This is the best place for our [relative] to receive care and support. We have tried a few homes that we are not happy about before we decided to bring him here, which was the best decision we have made, [our relative] feels safe and secure." Another relative told us, "The home is safe, it's been challenging but it is the nicest place, staff help with complex medication but the home has been understaffed."

Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Records confirmed that staff had received training in safeguarding people. Staff also confirmed that they could access the safeguarding policy. They were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the Care Quality Commission.

Accidents and incidents were recorded and actions and learning identified as a result of the incident were implemented. Staff knew how to report accidents and incidents.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment.

Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

People were protected by the use of safe infection control procedures and practices. Staff were trained and kept up to date with good practice. The home smelt clean and fresh at all times. Liquid soap and paper towels were available in bedrooms, bathrooms and toilets where personal care was provided.

Good

Is the service effective?

Our findings

During our last inspection on 10 May 2016, the home was in breach of regulation 14 associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that people's fluid intake was not always appropriately recorded. The provider sent us an action plan telling us how they would ensure this was addressed. At this inspection, we found that improvements had been made to the recording of people's fluid intake.

Fluid charts had specified a target fluid intake and had been completed for both day and night with most fluid charts totalled and signed each day, although some had not been. One person, whose fluid chart we looked had been prescribed a thickener which details of had been included in their care plan and was displayed in their bedroom. This person was also fed via a Percutaneous Endoscopic Gastrostomy (PEG) and details of the supplements given and cleaning was recorded.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. We saw evidence where a risk was identified a care plan was implemented in order to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. Weight loss was recorded and referrals were made to a dietician in a timely manner.

We checked pressure relieving equipment in place at the home and found that equipment such as pressure relieving mattresses and cushions in good working order and condition, and checked on a yearly basis. However, one AIR mattress had been set at an incorrect weight setting for the person using the mattress. This was reported to the general manager for immediate action.

Referrals were also made to a Speech and Language Therapist (SALT) when concerns were noted as regards people's ability to swallow safely. However, on second day of the inspection, a visiting SALT told us that she observed staff not following SALT recommendations which had been displayed in the person's bedroom and recorded in their care plan. This meant that the person was placed at increased risk of choking or aspiration related illness. We brought this to the attention of the general manager during the inspection.

We completed observations at lunchtime on all three floors on two days of the inspection. Although lunchtime was observed to be busy, the general atmosphere in the dining rooms was calm and unhurried. No one was being rushed with their meal and staff were chatting and joking with people which was having a positive effect on their well-being. Staff from other areas of the home, including an office administrator and two activities coordinators and deputy manager were deployed to the ground and first floors to assist with supporting people to eat. Relatives were also observed assisting at mealtimes on the ground and first floors and were offered a meal when assisting their relatives. A relative told us, "The carers are very rushed off their feet so I come in to help." We observed kind and caring interactions when people were being supported to eat in their bedrooms and all people received their meals in a timely manner.

Menus were on display throughout the home and people were offered a choice. We saw that alternatives were provided where people did not want what was on the menu. People's dietary requirements, whether medical or religious was displayed on the wall on the kitchen. People were positive and highly complementary about the standard of meals and the choices available. One person told us, "The food is good." Another person told us, "The food is not too bad. The chef minces it all and puts it in little piles on my plate." A relative told us, "The chef is fantastic."

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments from people included, "The staff are very nice. They don't moan and they are very good" and "The staff are very good." Comments from relatives included, "The carers and nurses are fantastic", "[name of staff] is on the ball," and "I have no concerns about the nurses and carers." A member of staff told us, "We try to do a good job so that we meet their needs."

The service had systems in place to keep track of which training staff had completed and future training needs, staff supervisions and appraisals. Staff told us that they had access to training and had received regular training. One member of staff told us, "It's good training." Another member of staff told us, "The training is okay." Training records confirmed that staff attended regular training which included infection control, manual handling, choking and dysphagia, mental capacity/DoLS, food safety and safeguarding.

Staff told us that they received regular supervisions and appraisals. The general manager told us that a number of annual appraisals were now due and it was a priority to ensure they were completed. We looked at staff supervision records and noted that they were in general task focused, for example, call bell response times, infection control and moving and handling. It was discussed with the general manager that supervision sessions did not appear to be personal to the staff member and did not address development needs.

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. We checked whether the service was working within the principles of the MCA.

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). Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for authorisation.

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Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty and Safeguarding (DoLS) had been provided and staff demonstrated an understanding of MCA and DoLS and when these should be applied. One member of staff told us that MCA referred to, "People who can't make a decision for themselves and we make decisions. A DoLS is for their own protection for example putting a code on the lift or a bedrail." Another member of staff told us, "If a person has is able to make his decisions but if for example if someone has dementia and has bed rails I would do a MCA with the family and carers and we have a discussion about what is in the persons best interest. We would also still explain to the person what we are doing."

People and staff told us that consent was obtained prior to assisting people. One person told us, "They discussed tasks with me before they do it." A member of staff told us, "Everything – I have to let them know

and always tell them what I am doing so we know what they want."

People were supported to maintain good health and have access to healthcare services and received on-going healthcare support. One person told us, "I have many health problems, when I was unwell the nurse acted very quickly, she called the doctor, but if I am at home I may not get the help that quickly." Care plans detailed records of appointments with health and care professionals. We also saw evidence that following appointments, people's care plans were updated accordingly.

Good

Is the service caring?

Our findings

Staff were caring and supportive towards the people who used the service. A person who used the service told us, "The staff treated me kindly and with respect, they are very supportive." A relative told us, "[My relative] is looked after very well if we highlighted issues, the staff knows his needs in terms of preferences, he likes football and loves monkeys. When we visited we saw him watching football and documentary about monkeys. We are very happy about this." Another relative told us, "The staff are wonderful."

We observed kind and positive interactions between staff and the people they were supporting. Staff were gently orientating people when appropriate. Staff were maintaining some physical contact such as hand holding where this was appropriate and calming for the person. Staff were offering choices with regard to where people wanted their lunch and what they wanted to eat.

Staff told us they enjoyed working with the people on the dementia unit and that this was one of the reasons they enjoyed working at the home. We could see that positive relationships had developed between staff and people using the service. We observed that one person at times became distressed and called for family. Staff responded to the person in a patient and caring manner. A member of staff explained to us that when the person became upset, she responded well to a particular member of staff. We observed this member of staff provide reassurance to the person.

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. Staff told us they had read peoples care plans. Care plans were detailed and person centred and were reviewed and updated on a regular basis. Care plans described people's cultural heritage as well as whether or not people chose to adhere to a religious faith. On one day of the inspection, a religious minister attended the home to administer holy communion to people who chose to receive.

We spoke with people and relatives about whether they felt involved with their own care provision or the care provision of their relative. A relative told us, "They involved me in the care planning of [my relative]." Another relative told us, "We are always involved in everything, all decisions. They are so good; they are really quick to pick up as mum gets infections. I know I can approach them, the carers, the nurses and even the manager."

Staff respected people's privacy and dignity. We saw that doors were kept closed when people were receiving personal care. All the people we spoke with felt that they were treated with respect and that their privacy was protected. One person told us, "They close the door when I am having a shower. They are very good with personal care." A relative told us, "When they are supporting [my relative] to wash, the staff pull the window blind closed. They are treating him with dignity and respect. I feel that the care standard has improved a lot. Staff make suggestions on the type of clothing to buy for him as they are struggling with dressing and undressing with his current clothing."

The home had recently been refurbished and people's rooms were tastefully decorated. Rooms were personalised with family photos, ornaments and pictures. A relative told us, "All sorts of systems have been

set up by staff to make [my relative] feel at home. We are involved in his support plan. Lots of visual stuff from home has been put on the wall and information about his food preferences has also been put on the wall to help him feel at home."

We observed a steady stream of visitors throughout our inspection. A relative told us, "The fact that we can come to visit any time we want with no restriction makes us happy".

Requires Improvement

Is the service responsive?

Our findings

People using this service and their relatives told us that the management and staff responded to any changes in their needs. We saw from people's care records and by talking with staff that if any changes to people's health were noted by staff, they would report these changes and concerns. Relatives told us they were kept up to date with any issues. A person told us, "The girls here are fantastic. They pick up signs if I have a urinary tract infection and they prevent me being admitted to hospital." A relative told us, "[My relative] had a nurse come in and check her and I was sent a copy of the letter. The social worker also visited. The nurses do tell me and if [my relative] gets any skin blisters they always tell me."

People's individual care plans included information about life history, cultural and religious heritage, daily activities and communication. Care plans were reviewed regularly and updated as changes occurred. Through our observations and discussions with staff they demonstrated an awareness of people's preferences, what people were able to do and what they needed support with.

The service employed three activities co-ordinators: one full time and two on a part time basis. An activities timetable was displayed throughout the home. We observed activities taking place either in a group or on a one to one basis. These were being undertaken by the activities coordinator and another activities coordinator who we were informed had come from another home. Staff told us that they were unable to take part and assist in most activities as they were very busy. However, they said they did talk and engage with people when they were providing personal care or other task related activities. We observed on two days of the inspection relatives attend and hold a party in a communal area for a person who used the service. We observed the grand opening of the newly refurbished dementia unit which included a drinks reception for people, relatives and members of the community. We also looked at thank you cards received from relatives following the summer barbeque which and received positive comments from staff and relatives about the success of the barbeque.

The inspection team observed that most people who used the service remained in their bedrooms and some people remained in bed throughout the day. We observed that some people were receiving end of life care. We asked the general manager about this and he told us that people chose to remain in their bedrooms or stay in bed. A member of staff told us, "This is to avoid getting pressure ulcers." However, one person we spoke with told us, "They leave me in bed. I do need the exercise. I don't know where the lounge is." A relative told us, "[My relative] did not get out of his room for many weeks. We complained and now he is out in the lounge." We observed one person remain in bed on one day of the inspection who had been in the lounge the previous day. When we asked staff about this, we were advised that they were unable to locate trousers for the person that morning. We also received feedback from a healthcare professional, where concerns were raised regarding people not being supported to mobilise and rehabilitate as, in their view, there was a lack of staff to accommodate hoisting.

During the inspection, we also observed people in communal areas sitting in wheelchairs, as opposed to sitting in seats. We discussed this with the general manager on the second day of the inspection and people were subsequently supported to sit in the chairs in the lounge. On the third day of the inspection, we

observed four people sitting in the lounge, all of whom were in wheelchairs. We brought this to the attention of the general manager who advised us that two of the people observed preferred to remain in wheelchairs. We also observed instances where people were left for periods of time with little or no interaction. This was because staff were busy supporting people with their task based needs.

We checked how the service handled complaints. We saw that any complaints received had been investigated fully and appropriately, in line with the home's policies and procedures. Responses from senior management were open and detailed. Where mistakes had been made these were acknowledged and apologies provided. Responses also included lessons learnt by the organisation. People and relatives told us that aside from on-going concerns relating to staff levels, they generally had no other complaints or concerns. People and relatives told us they knew how to complain. A relative told us, "I was concerned about the condition of the bed linen, I mentioned it to staff and they had it changed. They have taken care of her issues, followed up any concerned that I might have raised and give feedback after".

There were arrangements in place for people and relatives to provide feedback. A questionnaire was sent to people and relatives on a yearly basis and the results were collected and analysed by an independent provider. We saw posters in communal areas and in lifts advising people and relatives that feedback forms had been out for completion in August and September 2016. The general manager told us that the feedback had not yet been collated or analysed. Relatives confirmed they had been sent feedback surveys with one relative telling us, "We always fill them in."

Good

Is the service well-led?

Our findings

People and staff spoke positively about the general manager. One person told us, "He pops in to say hello. He seems nice." A relative told us, "The new manager is very nice, very approachable, open door policy. He takes on board concerns and issues." Staff comments about the registered manager included, "He is approachable"; "He is hard working"; "The first month the manager came and got to know the residents," and "So far so good. To be honest, he is trying to consider our requests and follow up."

A deputy manager recently commenced employment at the home. The deputy manager provided nursing cover for 25 hours per week and 15 hours of managerial support. Staff spoke positively about the deputy manager. One member of staff told us that the deputy manager "Knows what she is doing, very confident, very calm and is very approachable." Another member of staff told us, "The new deputy manager is clinically very good." The deputy manager told us that she had recently taken over responsibility for completing staff rotas but advised that it was quite rushed as she has not had sufficient time allocated to completing rotas as she is working additional hours to provide nursing cover.

There were systems in place to monitor the safety and quality of the service provided. These included yearly quality surveys, monitoring of call bell response times, unannounced night spot checks, a daily stand up meeting and audits by senior management. The general manager told us, "The systems that are in place are very good."

The regional director carried out a quality visit in August 2016 where a number of quality issues had been identified. The general manager showed us the service's resulting action plan in place which identified areas for improvement, such as improving staff supervision and appraisal rates, more detailed admission assessments and full completion of food, fluid and repositioning charts. We saw clinical governance reports completed on a monthly basis which included recording every person's weight, every instance of a pressure ulcer, complaints received, safeguarding referrals and audits completed.

Staff confirmed they attended regular staff meetings and most staff told us they felt able to raise any issues or concerns. However, the minutes of a recent meeting did not reflect this. The minutes showed that changes and updates were communicated to staff but we could not establish if staff had raised any queries or were asked for input. The minutes of the meeting did not list attendees.

The general manager told us that a daily departmental stand up meeting took place and we saw documented minutes of a meeting which had taken place the day before the inspection started. Actions from previous meetings such as repairing call bells were monitored. Staffing was discussed and updates from healthcare professionals who visited the previous day.

Relatives told us that they attended meetings and could raise concerns. However, one relative who attended meetings told us they were not sent the minutes, which was reflected in the minutes of the last relatives meeting which took place in June 2016. We also looked at the minutes of resident and relatives meetings for January 2016 and October 2015. The home's chef attended the residents and relatives meetings and

discussed menu changes and requests from relatives as regards better presentation of pureed food which was observed on this inspection. Staffing levels appeared to be a recurrent theme in resident and relative meetings with residents and relatives expressing concerns regarding staff levels.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The service was not always adequately staffed in order to meet people's needs.