Mr Seamus Patrick Flood

Shannon Court Care Centre

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

We carried out this unannounced inspection on 13 January 2015. The service had not been inspected before under the current registration. Shannon Court Care Centre is registered to provide residential and nursing care for up to 76 people and specialises in dementia care.

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

The registered manager was overseeing night duties at the time of the inspection and the deputy manager was in charge of the home on the day. The deputy manager facilitated our inspection.

Summary of findings

The home had sufficient numbers of staff to attend to the needs of the people who used the service. The building was safe and secure and people who used the service told us they felt safe and their relatives said they felt their loved ones were safe.

Staff were recruited safely and the home had a robust induction process in place for both new and agency staff. Experienced staff were always on hand to assist newer staff members to ensure they worked in accordance with the home's policies and procedures.

There was an up to date safeguarding policy in place and staff were aware of how to recognise and report any safeguarding issues. Safeguarding issues were followed up appropriately by the home. We saw the home's medication systems which helped ensure medication was safely ordered, administered and disposed of.

We looked at nine care plans, which included a range of personal and health information, including monitoring charts for issues such as weight, nutrition, falls and continence. We saw that the staff at the home accessed support from other professionals and agencies when required. Care plans were person centred, detailing people's personal preferences, background, family links and interests.

People were offered a choice of meals and there was plenty food on offer. Drinks and snacks were available throughout the day. However, the meal time experience could have been enhanced by staff being more attentive to people who required assistance.

We saw that all staff undertook a comprehensive and robust induction procedure. Staff training was comprehensive, up to date and on-going.

Deprivation of Liberty Safeguards (DoLS) screening was carried out for everyone and applications for authorisation made appropriately. Staff had received training in the Mental Capacity Act (2005) (MCA) and worked within the legal requirements of the act.

The people who used the service we spoke with and their relatives told us they felt staff were caring. We observed staff treating people who used the service respectfully and offering care in a kind manner. Staff ensured people's dignity and privacy was respected.

We spoke with six professionals who visited the home, both before and during the inspection. They included three health care professionals and three social care professionals. They told us communication between themselves and the home was good, though there was the occasional miscommunication.

People who used the service and their relatives were involved in care planning and reviews, where appropriate. This was evidenced by speaking with people and looking at care records.

The home encouraged feedback from people in a number of ways. There had been an open day at the home, where people had been invited to look around, speak with staff and avail themselves of therapy on offer. There were feedback forms on the main reception desk, which people were encouraged to complete, and surveys were sent out annually to gain people's opinions and suggestions.

A monthly newsletter was distributed to update people on events and occurrences at the home. The home's complaints procedure was outlined on posters around the home. This included up to date contact details of various agencies that could be contacted if someone wished to make a complaint.

The home offered a range of activities and therapy, such as hand massage and aromatherapy, to people who used the service and there were two full time activities co-ordinators and a qualified aromatherapist employed at the home. People were encouraged to participate as much as they wished to.

We saw evidence of regular staff meetings and staff had regular supervision sessions and appraisals. Staff said they felt supported by the management team and people who used the service and their relatives felt the manager and deputy were approachable.

The home had an effective quality assurance system in place, which included a number of audits, analysis and action plans. Surveys and questionnaires were sent out annually to relatives, professionals and staff. Issues and concerns raised were identified and addressed via a quality report action plan.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service told us they felt safe. We looked at staff rotas and observed staff on the day of the inspection and there were adequate levels of staff to meet the needs of the people who used the service.

The building was secured with key pads and locks where necessary. People had personal emergency evacuation plans in place to ensure they would receive the help they needed in the event of a fire emergency.

The home had a robust recruitment process in place.

There was an up to date safeguarding policy in place and staff were aware of how to recognise and report any safeguarding issues.

There were systems in place to ensure medication was safely ordered, administered and disposed of.

Is the service effective?

Requires Improvement

The service was not always effective. People who used the service were facilitated to access medical and health support when required.

Care plans included a range of personal and health information, including monitoring charts for issues such as weight, nutrition, falls and continence.

The food was good and plentiful and there was choice around meals. However, the meal time experience could be enhanced by more attention from staff around people requiring assistance.

Staff were given a robust induction process and staff training was comprehensive, up to date and on-going.

Deprivation of Liberty Safeguards (DoLS) screening was carried out for everyone and applications for authorisation made appropriately. Staff had received training in the Mental Capacity Act (2005) (MCA) and worked within the legal requirements of the act.

Is the service caring?

Good

The service was caring. We spoke with people who used the service and their relatives and they told us they felt staff were caring.

We observed staff treating people who used the service with respect and preserving their dignity and privacy.

Professionals we spoke with said there was usually good communication between themselves and the home. Where this was not the case, the staff promptly rectified the situation.

Summary of findings

We saw a range of evidence that people who used the service and their relatives were involved in care planning and reviews.

Family and friends had been invited to an open day at the home, where they could speak to staff, look at care plans, with their relative's permission, and look around the building.

There was a monthly newsletter distributed to update people on events and occurrences at the home.

Is the service responsive?

Good

The home was responsive. We saw that the complaints procedure was outlined around the home and comments and suggestions were encouraged from people in a range of ways.

Care plans were person centred, detailing people's personal preferences, background, family links and interests.

There was a range of activities and therapies, such as hand massage and aromatherapy, on offer and recorded evidence that staff were led by the people who used the service with regard to offering these services.

Is the service well-led?

Good

The service was well-led. Staff reported they felt supported by the management and people who used the service. Relatives and staff all said the management were approachable.

Staff had regular supervision sessions and staff meetings were undertaken on a regular basis.

Surveys and questionnaires were sent out annually to relatives, professionals and staff. Issues and concerns raised were identified and addressed via a quality report action plan.

The home had an effective quality assurance system in place, which included a number of audits, analysis and action plans.

Shannon Court Care Centre

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on 13 January 2015. The inspection team consisted of a Care Quality Commission (CQC) adult social care inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone with appropriate skills and experience in a field related to the service provided at the location to be inspected.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the home in the form of notifications received from the service.

Before our inspection we contacted Bolton Local Authority contracts team who commission services from the home to find out if they had any concerns about the service. We also contacted six health and social care professionals who provide care and support to people living in the home to ascertain their experiences of the service. These included three social care professionals and three health professionals.

One the day of the inspection we spoke with three people who used the service, eight visitors, two professional visitors and seven members of staff, including the deputy manager. We looked at records held by the service, including nine care plans, four activities files, four therapy files and five staff files.

Good

Is the service safe?

Our findings

We spoke with three people who used the service about whether they felt safe. All told us they felt safe and secure within the home. One person said, "I am safe from falling here, I've tippled over once or twice since my stroke before I came here, but here they help me move about".

We spoke with eight relatives; some said they felt the environment was protective for vulnerable people. One person told us, "The care the staff provide to my [the person] and other residents is always well provided. I feel my [the person] is safe here". They went on to say that their relative had a low bed and crash mat to help keep them safe. We observed these pieces of safety equipment in situ in the person's bedroom.

Another relative commented, "My [the person] started wandering, that's why she came in here, she can walk safely in here and not come to any harm". Another said, "We have peace of mind about [the person] being in here; they (the staff) made her feel at home and safe".

One relative explained that their loved one's mental health had deteriorated, resulting in them sometimes throwing objects. The staff had responded by arranging a discussion with the family, resulting in them removing any objects from the person's room, which may potentially cause harm to them or others.

We spoke with three people who used the service about staffing levels. All felt there were enough staff on duty to meet people's needs. Comments from relatives were mixed. One person said, "Sometimes they are short-staffed and you have to wait if [the person] needs anything". Another said, "There always seems to be quite a few staff when I visit, but I've not been in the afternoon yet so I don't know if that's the case all the time". A third person told us, "Sometimes they are short-staffed and I think that has an impact on their quality of life. My [the person] is well cared for, but not consistently".

We spoke with seven members of staff. We asked if there were ever occasions when there were not enough staff on duty. They said they felt there were always enough. One staff member said, "We always have plenty of staff on duty, we can care for difficult residents as there is always a mix of experience of staff you can call on. Another told us, "I feel comfortable to ask for help and feel safe in delivering care".

The deputy manager told us they endeavoured to cover for annual leave and sickness with other regular staff members. Agency and bank staff were only used in emergencies, to help ensure consistency of staff for the people who used the service. We saw evidence that any agency staff used were given an appropriate induction and were not left to administer medication on their own, to help minimize the risk of errors.

We observed throughout the day that there were plenty of staff around the home, attending to the needs of the people who used the service, for example, assisting to eat their meals, assisting to the toilet and sitting talking to people.

We looked at staff rotas which indicated there were enough staff on duty for each shift. We asked the deputy manager how the number of staff required was calculated. She told us that she and the registered manager worked out the dependency needs of the people who used the service. She said the staffing level was flexible, depending on the particular needs of the people who used the service at any one time.

We looked at five staff files and saw that the home had a robust recruitment process. This included obtaining references and proof of identification. Disclosure and Barring Service (DBS) checks were carried out for all new staff to ensure their suitability to work with vulnerable people.

We were taken on a tour of the building and saw that appropriate key pads and locks were in place to help ensure the safety of the people who used the service. There were personal emergency evacuation plans in place for each person who used the service. These outlined people's dependency levels to help ensure the appropriate assistance would be given to each person in the event of a fire emergency.

We saw the home's safeguarding policy and procedure, which was up to date. We had reviewed information held by the CQC prior to our inspection and observed that safeguarding procedures were followed appropriately, issues responded to promptly and meetings attended and contributed to as per local authority guidelines. We saw that the home monitored and analysed results of safeguarding issues and lessons were learned from these to facilitate continual improvement to the service.

Good

Is the service safe?

We saw the training matrix which demonstrated that safeguarding training was undertaken by all staff and was on-going. We asked staff on duty how they would deal with any safeguarding concerns. All demonstrated knowledge of the policy and procedure and had undertaken relevant safeguarding training. One staff member described this as, "Ensuring the residents are safe, not in danger". They went on to say they would get help from someone else if needed and report the incident to whoever was in charge. The staff spoken with told us that all the senior staff were approachable.

The home had an up to date whistle blowing policy in place. A whistle blowing policy concerns staff being able to report any poor practice, under performance or potential abusive practice they may witness. Staff we spoke with were aware of this policy and knew how to report concerns. There was also an anti-bullying policy to help staff feel safe.

We saw there was a medication policy in place and staff told us they received regular updates and training. This was further evidenced via the training matrix.

The manager who cared for people living with dementia explained the procedure that all the registered nurses followed regarding medication management. They told us how medication was originally prescribed, via assessments and treatment recommendations from health professionals. There was evidence of this in people's care records. The unit manager showed us the Medication Administration Sheets (MAR), each of which contained a photograph of the person. There was a space for a signature from the person who used the service, to consent to having medicines administered by staff, but these had not been signed. Therefore there was no formal written consent to medication administration by the people who used the service. However, there were medication plans and recording of preferred methods of receiving medication within people's care files, indicating that discussions between staff, people who used the service and their relatives had taken place.

We asked about covert medication, which is a method of giving medication without the person's knowledge, when they are unable to make an informed decision and the medication is given in their best interests. We saw, within the care files we looked at, that some had covert medication risk assessments and GP letters.

The unit manager told us that standard practice, where it had been assessed that an individual had a need for covert medication, was for the registered mental nurse (RMN) to support the person who used the service to see their GP. The outcome would generally be that the GP would issue a letter recommending and authorizing the administration of covert medication. The letters we saw detailed the reason for the intervention and the risk to the person if the medication was not given covertly.

We saw body charts that demonstrated which areas of the body prescribed creams should be applied to. Staff we spoke with told us, "We are shown by the nurse where and how to apply any cream to a resident. We can always look up on the chart in their medication file if we are not sure". All medication records were relevantly dated and signed by registered nurses.

We observed the nurse dispensing medicines safely from personal medication blister packs, to people who used the service, who were supported with verbal prompts in a dignified manner to take their medicines. All blister pack medication was clearly labelled with the person who used the service's personal details on. All medicines, including controlled drugs, were stored in locked cupboards and we observed the nurse held the keys to any medication cupboard. They told us these keys were handed over to the next registered nurse on the following shift.

Requires Improvement

Is the service effective?

Our findings

People who used the service and relatives said they had good access to health and medical support when they needed it. District nursing staff were observed in the home during the inspection dealing with people who used the service. One person who used the service said "I had my eyes tested yesterday; the optician came here to do it".

One relative said, "They are good at sending for the doctor here, I'm happy [the person] gets to see the doctor when she needs to. In fact the doctor came out to see her on Friday as she was not well". Another relative commented, "The chiropodist visits once a fortnight to see to [the person]'s feet". A third told us, "The optician has been to see [the person] about some new glasses, she keeps losing them since she came in here, they can't keep an eye on everything all the time".

People who used the service said the food in the home was good and plentiful. One said, "The food is good here. Another told us, "The food is a big improvement on other places I've been, it's a lot better than Meals on Wheels and there's always plenty to eat".

During the inspection a lunchtime service in the dining room was observed. The dining room was located in between the two dementia units on the ground floor and lunch was served in two sittings, one for each unit. In the first sitting there were fifteen people sitting at five tables with one person on another table being encouraged to eat and assisted by a relative. The second sitting consisted of fifteen people, with five of the people from the first sitting remaining in their chairs for the second service. It was observed that two people who used the service did not enter the dining room but were assisted with their meals in the lounge by staff.

Staff served plated meals from the kitchen server; most people who used the service had napkins to protect their clothing from food debris. People were offered a choice of hot meal of cooked spam, baked beans and either small roast potatoes or mashed potatoes or soup and sandwich and a choice of hot tea or coffee or a cold drink of lemonade. Drinks were served in plastic mugs and dessert was a sponge cake and custard, served in plastic bowls. We asked the deputy manager why plastic items were used and she told us they felt this was more practical and easier for people to use as they were lightweight.

Although staff assisted some people whose care plans indicated they required help, during the meal, others who used the service were observed to be having difficulty eating their food, either due to a lack of dexterity or reduced cognitive ability. Occasionally staff would notice the difficulty and sit beside a person to assist them, but four people struggled for many minutes before staff recognised the need to intervene. In two instances people began eating their sponge and custard with their fingers as they could not work out how to use the spoon or were not aware that the spoon was available to use.

In three instances food found its way to the floor and the table top as people who used the service did not have the dexterity or co-ordination to keep the food on fork or spoon from plate to mouth. These people were not offered special utensils, plate guards or food they may possibly be able to handle more easily. The experience was frustrating for some people who used the service. The meal was conducted in a calm and relaxed atmosphere with interactions between staff and people who used the service characterised by respectful and courteous exchanges of encouragement and support, which would have been much improved if the observational skill of the staff had identified the need to intervene in a more timely way, to preserve the dignity of those people having obvious difficulty eating.

Snacks and drinks were offered throughout the day and food and drink was plentiful. However, the meal time experience we witnessed could have been improved by the home following current good practice guidance around enhancing the dining experience for people living with dementia. We saw evidence that monthly audits of the dining experience were undertaken and the deputy manager felt any issues would have been picked up and addressed via these audits. However, she agreed to address the concerns raised immediately with all staff members, to try to enhance the experience for people who used the service.

We recommend the service consults current best practice guidance on eating and drinking well for people living with dementia.

We looked at nine care files, three of which we case tracked to ensure all care needs were followed through. We saw the files included a range of health and personal information, which was regularly reviewed.

Requires Improvement

Is the service effective?

There was evidence of consent being given for care and treatment via signatures within care plans obtained from people who used the service, or their representatives. Pre-admission assessments and baseline assessments were also signed and dated. Monitoring charts regarding issues such as weight, nutrition, and falls were included where necessary and completed appropriately. There were records of GP and hospital visits and end of life advanced care plans. We saw recorded evidence, via letters and reports, of the home working with other agencies and professionals, such as social workers, dieticians and continuing health care assessors. However, not all documents were fully completed. We observed on an end of life plan there was no NHS number and no diagnosis recorded.

Each care file included a Deprivation of Liberty Safeguards (DoLS) screening assessment. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw that DoLS authorisations had been applied for, or were in place, where appropriate.

The home had a policy on consent, which included guidance around the Mental Capacity Act (2005) (MCA). The MCA sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times. We saw evidence within the care records that people's mental capacity was assessed, in line with the MCA, and this assessment was updated on a monthly basis.

In all records there was evidence of appropriate risk assessments and staff we spoke with were able to give a verbal explanation of how they managed risks with specific people who used the service, whose behaviour may challenge the service. They demonstrated a good knowledge of how to keep people safe. One staff member gave a specific example of how a particular person was supported with their anxieties. They told us, "We support [the person] to go to the local shop, where she buys a local newspaper. When we return to the unit we read the newspaper with her and talk to her about what's going on in the local community. This helps settle her".

We observed basic tick list behaviour assessments completed by dementia unit staff which did not give a detailed description of a person's presenting behaviour, though we observed good written evidence in care plans of how the presenting behaviour of the individuals affected their daily living and strategies on how staff should manage this behaviour.

Staff we spoke with gave us detailed information on how they supported people who presented behaviour that challenged the service. One staff member said, "I would know and learn from the resident's life history, care plans and senior staff that the resident has difficulty engaging in their care and may display difficult behaviour". Another told us, "I would follow the guidelines in the care plan

We saw evidence of regular updates and reviews in the personal care records. There was also a separate record file that daily updates were collated and written in by the Registered Nurse. However, not all documents were fully completed and we observed on an end of life plan there was no NHS number and no diagnosis. On one behaviour tick list assessment we observed that there was no staff signature and no date.

One person who used the service had been referred to a Community Mental Health Team (CMHT), Dementia Intensive Support Team via their GP. Relevant documentation and letters from the consultant psychiatrist and the team were appended in the personal care record. There was a care plan that had been written by the unit RMN detailing guidelines relating to the management of that person, which the nurse said had been developed from the CMHT care plan.

All the staff we spoke with said they had a good induction process, in which they completed mandatory training and shadowed a more experienced staff member for the first couple of weeks at work. They felt this gave them confidence. We looked at five staff files and saw evidence of the induction process within each file.

We saw the training matrix which demonstrated a commitment by the home to a comprehensive programme of training for all staff. We looked at seven staff files which also evidenced a range of training courses undertaken by staff. A number of staff had undertaken dementia awareness training, MCA and DoLS training. The deputy manager told us there were plans for all staff to undertake MCA and DoLS training and this was evident from the training programme.

We spoke with staff on the dementia unit, who told us that they had undertaken the relevant safeguarding, mental

Requires Improvement

Is the service effective?

capacity and dementia training, and said they know what to do to keep people safe. They all told us that they felt they had adequate training to meet the needs of people who used the service who were living with dementia and displayed behaviour that challenged the service.

Staff said their training was regularly updated and carers said they always had someone to seek advice from such as nurses and unit managers.

We saw there was adequate colour coded signage to assist people living with dementia with orientation around the home. There was also an orientation board displaying the day, date and weather. We saw that menus were produced in a pictorial format and there was also a menu board. The environment was bright and had good lighting and there were quiet areas such as the conservatories where people who used the service could sit and some reminiscence areas.

We saw that people's rooms were located via street names, in colour coded corridors. This helped the home seem less institutional and more like a regular community. Some people had memory boxes located outside their rooms, but we were told this was down to their and their relatives' choice. There was adequate room for people to walk around freely. We saw evidence of some meaningful one to one interactions between staff and people who used the service, for example, chatting about their family. People had access to outside space in the summer months. People's care plans included personal activities plans which were formulated with regard to people's wishes and information gained from relatives about past interests.

We asked the RMN and deputy manager to show us evidence of how they adhered to the national recommendations, such as National Institute for Health and Care Excellence (NICE) quality standards for dementia care, to evidence that they deliver a quality based service for dementia care and older people.

The deputy manager informed us that they did not use national guidelines to set the care centre standards, nor use them to measure the quality of care they delivered, but used a locally developed system called 'MERLIN' that described what good care should look like, including audits they conducted to measure the standards. We saw evidence of this system in the home. They also adhered to Clinical Commissioning Group (CCG) request to complete relevant safety thermometers to evidence they were delivering a quality based service. Staff had an awareness and understanding of dementia national guidelines and best practice incorporated in all relevant dementia training.This was evidenced in staff training records.

Good

Is the service caring?

Our findings

We asked three people who used the service if the staff were caring. One told us, "The staff are very good to me". A second said, "The staff are very helpful, there's always someone about if you need them". They told us there were no restrictions on visiting. One person told us, "My [relatives] live near here and visit me when they want".

We spoke with eight relatives and one told us, "The staff here are fantastic". Another said, "I have seen the staff treat other residents as if they are their own family, and they speak to them as if they can understand. They always explain to them what they are doing".

Relatives we spoke with said the staff generally treated people with dignity and respect. One commented, "They treat [the person] very well, I've been in a few homes and this is the best, they treat everybody with respect". Another said, "They look after people very well, they can't do enough for them". However, one relative said "I think the staff have good training, but sometimes they don't always seem respectful, it's a bit inconsistent".

We contacted a number of professionals and other agencies prior to our inspection. One professional agency told us, "Staff always helpful and approachable, communication lines are open and we are often put through to the senior nursing staff if we have any queries. They (the staff) were particularly helpful in implementing the care plans for our patients". One professional said that a care plan put in place for their patient had not been followed correctly in the first instance, resulting in the person having to receive food supplements. However, this was quickly rectified once it was pointed out.

We spoke with two visiting health professionals on the day of the inspection. One told us they regularly visited the dementia units to conduct reviews of care plans. They told us, "I am always impressed when I hear how staff treat the residents; they are always respectful when speaking to the residents. There is a relaxed atmosphere here, it appears very person centred".

When asked if they were involved in their relatives' care people spoke with familiarity about the care plans and confirmed they had been in discussions with staff about their relatives' care needs and how they would be met. One person told us, "Staff come and talk to us about [the person] and what she needs. They keep us up to date with what's going on with her and what they have been doing about it". Another relative we spoke with gave examples of their family's involvement in all aspects of their loved one's care. They stated that, when their relative was admitted, they were given all the relevant information about the home, and went on to say, "My family and I have always been involved in all aspects of care, review meetings, any best interest decision making, her end of life plan. I am aware of our [the person]'s care plan and I have seen it". Another person told us, "I've had talks with the staff in the office about my [the person]; I've found them helpful and have been reassured by the conversations".

We also saw written evidence of relatives being involved in assessments, care planning and evaluation in people's personal care records. We saw evidence of end of life care plans in people's personal care plans completed 'in the best interest' of the person who used the service. These were completed with the person's relatives, staff and relevant health professionals such as GPs and consultant psychiatrists. A relatives told us, "I and my (relative) have been involved in an end of life care plan for my [the person], as we know she would want to end her life here in the home where she is loved and cared for, not in a hospital".

During the inspection visit we heard staff speaking respectfully to people who used the service and relatives. We saw a member of staff taking to a person who used the service about their personal history, school and working life. We saw that the person became happily engaged in the conversation and it was clear that the staff member had a good working knowledge of the person's history, likes and dislikes.

All the staff we spoke with was able to give us examples of how they maintained a person's privacy and dignity. One staff member told us, "I would know and learn from the resident's life history, care plans and senior staff that the resident has difficulty engaging in their care and may display difficult behaviour. I would follow the guidelines in the care plan". They went on to say that one person who used the service was resistive to being helped with personal care. They said, "It is most important to maintain his dignity and privacy. It is good to engage in conversation before supporting him with the task this distracts him".

Staff we spoke to also gave us information about how the relatives were affected by their loved ones' diagnoses of dementia and behaviour that challenged the service. They

Good

Is the service caring?

were able to give examples of how they supported the family as well as the person who used the service. We observed throughout the day staff sitting talking to relatives who were visiting their family.

A relative also told us that family were encouraged and invited to join in activities held at the home, for example Thursday morning coffee mornings. There was a poster on a notice board with details about the coffee morning. There were also signs on the notice boards about visiting clergy from the local church and one such visit took place on the day of the inspection.

The deputy manager told us they had recently held an open day (2 pm until 7 pm) for relatives and friends to attend. Relatives' meetings held in the past had had limited success, due to people's work commitments and possibly the formality of these meetings, so this had been an experiment to see if it worked better. The open day had been a great success and had been attended by 27 people, some of whom took the opportunity to have a private word with staff or look at their relative's care plan, others availed themselves of the therapy on offer and some had a look around the home. Staff and management were available throughout the afternoon for people to speak to and there was a suggestion box for people to utilize if they wished to and a leaflet explaining Deprivation of Liberty Safeguards (DoLS) was given out to people. The deputy manager told us they now had plans to repeat this event at regular intervals.

We saw evidence of a newsletter produced by the home. This outlined recent and upcoming events. We saw that it had been changed from three monthly to monthly as a response to suggestions from people who used the service and their relatives.

Good

Is the service responsive?

Our findings

There were a variety of comments made by people who used the service and their relatives, about the levels of stimulation and activities for people who used the service. One person who used the service said, "I usually spend my time sitting here. I'll sometimes go outside if it's nice, but mostly I'm in here or in the dining room for my meals. Another said, "I don't mind having to come in here; it's something that had to be done. I'd sooner be in a place like this where I am now than be on my lonesome".

One relative we spoke with said, "There's lots of things going on for them here, exercises, pass the ball, coffee mornings, parties and the like. [The person] has her legs done by the therapist downstairs, she oils her legs". Another relative said, "I think there are enough activities to stimulate [the person], we got invited over at Christmas and there seemed to be a lot going on". A third relative told us, "There's information on the notice boards about what's going on, we get invited to some of the activities and we come when we can".

We asked what people would do if they had a concern or complaint. None of the people who used the service expressed any concerns about their care or any services provided in the home. One relative said, "I know what to do and where to go to if I have concerns or a complaint. I feel confident that I would be listened to and it would be acted on". Another commented, "I've never had to make a complaint, but if I had any worries I would talk to (staff member)". A third said, "I have no complaints, but if I had any I would talk to the staff in the office or contact my [the person]'s social worker".

During the tour of the building we saw there were notices in the corridors about the complaints procedure inviting people to make known their views to the registered manager or to CQC with appropriate contact details. Leaflets were available on the reception desk, requesting people offer comments, suggestions, concerns and complaints. We looked at the complaints log, but there had been no recent complaints made.

We looked at nine care plans and saw there was a significant amount of personal detail within the files, detailing people's histories, interests and preferences. We saw that people's preferences with regard to things such as shower or bath, times of rising and retiring, were adhered to.

We observed personal life history documents that had been completed by relatives, this assisted staff to create a person centred approach to caring for the individual person. There were documents entitled "All about me" and "This is me" within the files, which gave detailed information about people's individual personalities. Some documents were produced in an easy read format, to help enable people who used the service to be involved in the reviews and updates.

The home was well-resourced with staff ancillary to the carers and domestics on the floor. The home employed two activity co-ordinators, one of whom was observed during the inspection spending time with individuals and groups involved in playing games and general social interaction. However, we were told that one of the activity co-ordinators was absent from work and this seemed to affect people who were in the dementia units. We did observe staff having some discussions with individual people about their interests and family.

The home also employed a therapist who provides a range of massage and other physical interventions to support care of the people who used the service. We were informed that relatives and visitors were welcome to use the therapy on offer and, in specific cases; staff could also use this facility to promote their well-being.

Each person who used the service had a personal activities and therapy plan and we looked at four people's individual therapy and activity files and saw these were tailored to the person's needs and wishes. We saw that some people did not wish to participate in the therapy session and this was recorded. Staff told us they used gentle encouragement sometimes, as people often refused an activity, but would enjoy it if persuaded to participate. The therapist had clearly stated in the records when the person had asked for them to do the therapy more gently, or in a different place, and had adhered to the person's wishes. Consent to the therapy interventions was always sought and recorded.

We saw that therapy and activity files were produced in an easy read format where needed, with pictorial

Good

Is the service responsive?

representations and photographs; so that people could easily look back at activities they had participated in. All activities records also documented family meetings that had taken place.

Good

Is the service well-led?

Our findings

We spoke with seven members of staff, all of whom told us that they loved their jobs and felt valued and appreciated by managers and relatives. They all said they would recommend working at the home.

Staff informed us that they were well supported by their managers. One of the nurses stated, “I feel like I have been here a long time, all the staff work well together to achieve the same outcomes. The managers are very supportive; there is a good management team. I feel I have and will continue to have the relevant required training to do my job”.

Staff we spoke with were clear about who their line manager was and who to approach for guidance and support. Staff and relatives informed us they felt confident to approach the staff member in charge who they said was very knowledgeable and helpful.

Relatives we spoke with reported that the registered manager was approachable and informative about the on-going needs of their relatives. One said, “The home ring me up if anything happens to [the person] I should know about, like if they call the doctor”. Another told us, “They phone me if [the person] is not so well today”.

The relatives we spoke with said they had completed surveys and questionnaires asking for their views about how the home was run. One commented, “We haven’t been to any of their meetings but we have filled in some questionnaires which asked if we were satisfied with the care here”.

We saw that staff meetings were held regularly. Minutes were signed as read by those staff members unable to attend. We looked at the most recent minutes and saw staff issues, monitoring charts, end of life issues and environment had been some of the topics discussed.

We looked at seven staff files. There was evidence that staff had regular supervision sessions and annual appraisals. We saw that the home’s disciplinary procedures had been followed appropriately when required.

The home had a locally developed system called 'MERLIN' that described what good care should look like, including audits they conducted to measure the standards. They had achieved silver standard in investors in people and implemented the Gold Standard Framework, which is an accredited national training programme for end of life care. The home also completed a number of safety thermometers for the Clinical Commissioning Group (CCG).

Staff had an awareness and understanding of dementia national guidelines and best practice incorporated in all relevant dementia training.

We looked at the home’s accident and incident recording and this was complete and up to date. Audits were undertaken on a monthly basis, including an analysis of where, when and how injuries had been sustained with actions resulting from the analysis.

Complaints were audited regularly and there was a monthly training audit to evaluate staff’s attendance and completion of relevant training courses. Safeguarding was checked regularly to monitor the number and type of incidents.

Other checks and audits, such as health and safety, fire, falls and moving and handling were also carried out regularly and the results analysed and issues addressed.

Surveys were sent out annually to people whose relatives used the service, to ascertain their views. These were due to be sent out imminently. Professional visitors to the home were also asked to complete annual surveys, as were staff. The results were available for people to see in the form of an annual quality report. This then informed an action plan of improvements and changes to be made. We saw the last report from which a number of actions had resulted, such as a review of the menu and more vigilance to be used to ensure clothing was correctly labelled.