Family Care Private Company Limited

Conifers Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 April 2018 and was unannounced. The previous inspection took place on 15 October 2015 when it was rated as 'Good.'

Conifers Care Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation, for up to 20 older people, who are living with dementia and who require support with their personal care needs. On the day of our inspection there were 16 people living at the home. The home is a large property situated in Selsey, West Sussex. The home has 20 single bedrooms 11 of which have an en suite toilet. There was a communal lounge and dining room as well as a garden which people used. There is a passenger lift so people can access the first floor.

We found the premises were poorly maintained in a number of areas, including bedrooms, the kitchen, toilets and bathrooms. There were identified risks to people from the poor quality of the environment including exposed hot pipes in a bedroom posing a risk of burns to people and infection control risks due to a lack of wash basins in two toilets. These were in the older part of the building; the newer part of the building was well maintained.

Medicines were not always safely managed. Significant errors in the recording, handling and administration of some medicine were found. We made a safeguarding alert to the local authority about this.

The process of audits and checks on the quality and safety of the service had not identified and acted where we found attention was needed regarding the quality and safety of the premises as well as the safe management of medicines.

The provider did not always follow the correct guidance of the Mental Capacity Act 2005 and the associated Code of Practice. We have made a recommendation about this.

People and their relatives were satisfied with the standard and safety of the care provided. Staff had a good awareness of the principles and procedures for safeguarding people in their care.

Sufficient numbers of care staff were employed to ensure people were looked after well.

There were systems to review people's care and when incidents or accidents had occurred.

People's health and social care needs were assessed. There was a culture of supporting staff to attend training in current care procedures such as in palliative care and in supporting people who had needs regarding problems when swallowing food. Staff had access to a range of training courses including nationally recognised qualifications in care. Staff were also supported with supervision and their

performance was monitored by regular appraisals.

Health care professionals reported staff to be caring, skilled and as having good communication with community nursing teams

People were provided with varied and nutritious meals. There was a choice of food.

People were observed to receive care from kind and caring staff. People said they received care from kind and caring staff. For example, one person said, "They couldn't be kinder. They're absolutely lovely." People's rights to privacy and choice was promoted. The registered manager had sought guidance for staff regarding the rights of older people to have personal and sexual relationships. People were consulted about their care and how they liked to be supported.

People received personalised care that was responsive to their needs. This was also reflected in the feedback we received from people and their relatives; for example, one person told us, "Oh yes. Anything you want, you only have to ask and you'll get it."

Care plans reflected people's needs and preferences. A range of activities were provider for people to take part in.

The provider had a complaints procedure and records were made of any complaint or concern raised. These records showed complaints were looked into and a response made to the complainant.

Whilst there were no people in receipt of palliative care staff were trained in this and there were plans to extend this to more staff.

There were opportunities for people and their relatives to express their views which the provider responded to.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not always safe.

Risks to people were assessed and care plans in place to mitigate these but not all areas of the premises were safe or well maintained.

Medicines were not always safely managed.

The home was not always clean and adequate measures were not always in place to prevent the spread of infection.

Staff had a good awareness of their responsibilities to protect people in their care.

Staffing levels and recruitment procedures were safe.

The provider reviewed any incidents and took appropriate action so that lessons were learned.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to consent to care and treatment was assessed and where people's liberty was restricted applications were made to the local authority to authorise this as set out in the Mental Capacity Act 2005 Code of Practice. However, procedures regarding best interests' decisions for those unable to consent were not always followed. Where relatives made decisions on behalf of people it was not clear that the relatives with the correct legal authority had given the consent.

There were good procedures to ensure staff were well trained and supervised as well as having access to current guidance on caring for people.

People's physical health and social care needs were assessed and staff liaised with community health care services to ensure people received coordinated care.

People had varied and nutritious meals.

People had access to health care services.

Adaptations had been made to the environment and people were able to personalise their rooms.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind and caring. Staff promoted people's rights to choice, privacy and independence.

People were consulted and involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs, including social and recreational needs.

There was an effective complaints procedure where any issues raised were looked into and responded to by the provider.

Whilst there were no people in receipt of end of life care staff training and care records showed the service had policies and procedures for palliative care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's system of governance and quality checks had failed to identify and act on areas we found were unsafe, namely the controlled medicines procedures and the premises.

The culture of the service included staff being supported with training in current procedures and joint working with other agencies. Staff and management were committed to an open culture whereby staff and people felt able to approach the registered manager. People, their relatives and professionals views were sought about the quality of the service provided.

Conifers Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 April 2018 and was unannounced. The inspection was carried out by one inspector 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 service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people and two visiting relatives or friends of people who lived at the home. We spoke with three care staff, the registered manager and the administrative manager.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of medicines administered to people and complaints. We looked at staff training records and staff supervision records. We also spoke with a registered nurse who was a community sister and a Speech and Language Therapist (SALT) who were both from NHS and were visiting people at the time of the inspection. These professionals gave us permission to use their feedback in this report.

Inadequate

Is the service safe?

Our findings

The premises were not always maintained in a way that ensured they were safe for people to use. A number of wooden bedroom door frames were badly marked and chipped. In one bedroom we noted the flooring was rucked and beginning to rip in places which meant it was a potential tripping hazard. In a bathroom the bath enamel was worn, the grouting and tiling discoloured, flooring was damaged and the bath hoist was rusty. There was no privacy lock on the bathroom door. In a toilet, there were areas where tiles had fallen off the wall and where work had been done to conceal piping, this was only partially completed. In another toilet, tiles were loose and seven tiles had fallen off and two other tiles had buckled away from the wall and were not secure. In a bedroom there was peeling and chipped paint on a wall behind the person's bed. In another bedroom the cabinet housing of the wash basin had peeling veneer. Some bedroom doors did not have suitable locks that enabled emergency access.

In another bedroom there were exposed hot pipes running alongside a bed. The pipes were too hot to touch and posed a significant risk of causing a burn to the person in the room should they slide out of their bed. The risk assessment for the premises carried out in 2018 did not identify this as a risk. We made contact with the provider about this before the report was sent out and were concerned this had not yet been actioned more than a month after the inspection visit when it was raised.

The registered manager told us people could use a key to their bedroom door for privacy but we noted theses were not suitable as they did not allow staff access in an emergency. In order to combat this, the lock on one person's bedroom door had been removed, which left a round hole where the lock was once in place. At the time of the inspection this room was vacant but if a new person moved it would mean their person's privacy could not be assured.

There was a significant dip where a paved area had sunk which people and visitors used to access the main entrance. The registered manager said a cone had been placed near the sunken area to alert people to the area but had been removed by someone unknown. The registered manager confirmed this was due to be repaired but there were no dates of when this would be taking place. In the meantime this meant there was a potential for people and others to trip due to the sunken ground.

Whilst people said the home was kept clean and staff followed adequate hygiene routines we found people were not always protected by adequate measures to control infection. Whilst the home had been awarded a food hygiene rating of 4 stars on 20 July 2016 we found the kitchen had not been kept clean nor well maintained. A handle was missing from a kitchen door, tiling was dirty and there were bits of dirt above the cooker on a sloped tiled area which could fall into food. There were plug holes in the walls, chipped wall tiles and missing grouting. This meant the area could not be adequately cleaned to prevent the risk of infection spreading.

Two toilets which were used by visitors or people living at the home did not have wash hand basins; there was a sign to tell people to wash their hands in another area of the home which meant the user of the toilet had to go downstairs to wash their hands. This increased the risk of infection spreading in the home. The

registered manager was aware of this and said action was due to be taken to install wash basins in these toilets.

At the time of the inspection, the provider was unable to confirm when the last service and testing of the gas heating and electrical wiring had taken place. Following the inspection the provider made arrangements for these service checks to be completed and documents to support this were forwarded to the Commission. The provider had not ensured the checks on this equipment were effectively monitored.

The provider had not ensured the premises and equipment were safe to use for their intended purpose. The provider had not ensured adequate action was taken to prevent the spread of infection. This is in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Medicines were not safely managed. We looked at procedures for medicines which have specific legislation for storage, handling and recording as set out in the Misuse of Drugs Act Regulations 2001. We found these procedures were not always safe. When the medicine was received into the home, only one member of staff counted and recorded the medicine type and stock in the controlled drug register. The recommendation of the Royal Pharmaceutical Society is for a second staff member to witness this and record their signature. The home's procedure did not include any reference to this. We found there should have been five patches of a medicine for one person according to the controlled drug register, but the staff were unable to locate this medicine. A staff member contacted the supplying pharmacist and concluded this was due to a recording error by the home's staff who had recorded the wrong amount received and later the same day returned this by mistake to the pharmacist. At the time of the inspection a staff member crossed out previously written records in the register thereby making illegible records made at the time of the error. This would severely hamper any future audit /investigation of the records by either the provider or any external agency. From the records it was not possible to determine the audit trail of what had happened. Due to the errors in recording and handling procedures for this medicine the provider was not able to be assured that the person would have received the correct medicine in accordance with the prescribed instructions. We referred this to the local authority safeguarding team for consideration under safeguarding guidance. We checked the stocks of other controlled medicines and these correctly matched the records in the controlled drug register.
Medicines administration records (MARs)showed staff recorded their signature when they administered medicines to a person. These showed medicines were administered as prescribed. Where people had medicines on an 'as required' basis for intermittent symptoms, there was a lack of recorded guidance for staff to follow when this was needed. For example, one person was prescribed a tranquilising medicine for when they experienced 'severe agitation and anxiety.' There was no record of how these symptoms presented or what action staff needed to take to support the person in these circumstances. For another person who was prescribed medicine for pain relief, records did not show how this exhibited itself or if the person was able to ask for it.

The provider had not ensured the proper and safe management of medicines. This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several people did not have access to a call point within their reach in their bedroom. The registered manager told us this was because people had been assessed as not being able to use the call points. This, however, had not been formally assessed and recorded. One person and one relative we spoke with stated there was no 'buzzer' to call for help and said they would call out and that staff responded when they did this. A relative also told us staff made regular checks on people. We discussed this with the registered

manager who agreed the need include in the assessment of risks to people.

Staff were trained in the safeguarding of people and knew what to do if they needed to raise any concerns regarding the safety of people. This included being aware of the process for referring any concerns to the local authority safeguarding team. Each person we spoke with confirmed they felt safe at the home. Comments included the following: "Yes, you couldn't be better looked after." A health care professional also said they considered the staff provided safe care and commented, "Everyone is looked after well," and that staff followed safe moving and handling procedures.

Staff were aware of their responsibilities to alert any concerns or safeguarding issues. Incidents and safeguarding concerns were looked into and actions taken. These were recorded and showed the provider took appropriate action so that lessons were learned. Where incidents had occurred which were notifiable to the safeguarding team at the local authority there were records show these were looked into and appropriate action taken including any referrals to the Disclosure and Barring Service (DBS) regarding the actions of staff. The DBS maintains a record of those people who are not suitable to work in a care setting. The home's management demonstrated a commitment to the safety of people regarding these incidents and reviewed the home's procedures to ensure any reoccurrence was minimised.

Care records showed risks to people had been assessed and care plans devised to mitigate these risks. These were found to be comprehensive covering, swallowing food or drink, personal care, mobility and moving and handling. Risks regarding the use of bed rails were assessed and were reviewed each month. The risks of pressure area damage to people's skin was assessed using recognised assessment tools. Action was taken to mitigate these risks by the use of air flow mattresses and the repositioning of people. Charts were completed when people were assisted to be repositioned. There were corresponding care plans regarding how to safely support people to move, or to prevent them from falling and how to support to people who were at risk of weight loss or malnutrition.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical appliances, hoists, passenger lift and risks of Legionella. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked. First floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support them to evacuate the premises in the event of an emergency. The staff were trained in fire safety and the alarms and emergency lighting were tested as required. At the time of the inspection we observed the fire alarm being tested which activated the automatic door closers. There were contingency plans in place in the event of a fire or need to evacuate the premises. A valid certificate of liability insurance was displayed.

People and their relatives said there were enough staff. Between the hours of 8am and 2pm there were between three and four staff on duty. From 2pm to 8pm there were three care staff. Additional staff were employed to prepare and serve meals during lunch time and from 4pm to 6.30pm for the early evening meal. The hours worked by the registered manager and the administrator were in addition to this. The service also employed cleaning staff. Night time staffing consisted of two care staff who had access to 'on call' management support and advice. We observed there were enough staff to meet people's needs throughout the day and during the evening meal time. Staff said they considered there were enough staff to meet people's needs. A health care professional said that whenever they visited there were always staff available.

Staff recruitment procedures showed the required checks were made on newly appointed staff including the completion of an application form and employment history, obtaining references and a DBS check. The provider took appropriate action where staff performance was found to fall below an accepted level.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments had been carried out where people were unable to consent to their care and treatment. DoLS applications had been made to the local authority for each of the people living at the home and four of these had been agreed and granted. The Commission were notified of these as required by the regulations.

People told us they had consented to their care, or, where applicable, a relative said they had agreed to the care due to their relative not having capacity to do so. Where a relative signs to agree to care and treatment on behalf of someone else, this must done as part of a Lasting Power of Attorney (LPA) for the person's health and welfare or a 'best interest' decision making process. In one case the agreement to care was signed by a relative who was not the LPA for the person. For another person a relative had signed to agree to care on behalf of someone, but there were no records to show this person had the authority as a LPA to do this. We also noted this person had bed rails for their own safety. The use of bed rails entails some risk and a risk assessment had been completed. There was no evidence that the use of bed rails had been agreed as part of a best interest decision involving relatives and professionals. This is recommended as the procedure can be considered restraint. Following the inspection the registered manager took action to look into this and to make arrangements for a 'best interest' meeting regarding the use of bed rails for this person. We recommend the provider reviews and ensures the needs of people unable to consent to their care and treatment are in line with the procedures of the MCA and associated Code of Practice.

Staff had received training on the MCA and knew the principles of the legislation and the need to obtain people's consent. Staff were observed to ask people how they wanted to be supported and asked their agreement before helping them.

Care records showed people's physical, mental health and social care needs were comprehensively assessed both prior to and following admission to the service. Personal care needs were assessed in detail. Psychological and emotional needs were included. People and their relatives said staff provided care which met people's needs. For example, one person said, "Oh yes. Anything you want, you only have to ask and you'll get it." A relative commented, "You couldn't wish for him to be better looked after. You can go home and relax and know he's in safe hands. He needs everything doing for him and everything is done. He needs 24 hour care and he does get that here."

Health care professionals described the care and support as meeting people's needs and that staff were skilled. For example, a speech and language therapist said staff had recognised when a referral was needed because one person had difficulties swallowing food, adding that staff followed current practice guidelines for this. Another health care professional said, "We love this place. One of the best in the area. We have really good communication with the senior carer. Staff are up to date with current training."

Staff had a good awareness of people's right to services and good care irrespective of their age, sex or disability. The provider had policies and procedures on promoting people's rights. Staff confirmed they received training in equality and diversity as well as in human rights. The registered manager was committed to promoting people's rights and gave an example of the service taking positive action to ensure older people were able to exercise the right to personal relationships and had supported staff with current guidance in this.

The service employed 27 care staff assistants. Twelve of the care staff had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2, 3, 4 or 5. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff said the training was of a good standard, were able to discuss their training needs and how these would be met. Training was periodically updated in courses considered mandatory such as fire safety, health and safety, first aid, dementia, infection control and moving and handling. Staff also completed more specialist training in specific subjects in order that people's care needs could be met such as in continence, diabetes, communication, person centred care, physical health in dementia and food allergy. The provider utilised the training for staff which was provided by the local authority.

Newly appointed staff had an induction which they said involved a period of shadowing more experienced staff and enrolment on the Care Certificate. Records of staff induction were maintained and showed staff had registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff also said they were able to ask for a longer induction period if they did not feel ready to work unsupervised. A competency assessment was carried out on newly appointed staff before they worked independently. These were recorded and showed newly appointed staff were observed working with people as part of the assessment.

Staff said they received regular supervision and felt supported in their work. Records showed supervision took place regularly and involved staff and their line manager discussing their work as well as an assessment observation of their work with people.

People's nutritional needs were assessed using a recognised tool called a Malnutrition Universal Screening Tool. A nutritional risk assessment was also completed. A record of people's weight was maintained which showed people had maintained weight or that when they had lost weight the person's GP was contacted. A speech and language therapist (SALT) said people who had problems with swallowing were supported well by staff to ensure people were safely supported to eat. Records showed how people should be supported when they needed assistance with eating such as the use of fluid thickeners to aid swallowing. People and their relatives were satisfied with the choice of food and made the following comments: "I can't fault it. There's enough for all of us. They cook bacon better than I could! There's a menu, it's not huge, but there's enough choice. It's always nicely cooked and presented," and, "It's quite good. There is a choice. It always gets written down, what you want."

Meals were provided pre-prepared by a specialist supplier. A menu plan was available and showed people

were offered a choice of nutritious meals. Snacks such as biscuits and cakes were provided as well as fresh fruit. Nutritional supplements were used such as evaporated milk, double cream and specialist drink so calorie intake could be increased for people when needed.

We observed two meal times: the lunch and early evening meal. People had a choice of food and were offered more if they wanted. The food was well presented and staff supported people when needed. We observed drinks were available for people and a health care professional also confirmed this was their observation.

Health care professionals told us the staff and management worked well with them to ensure care needs were met and that any guidance given was followed. Referrals were made to a number of agencies such as the dietician GP, SALT and continence nurse. People said they received health care when needed. For example, one relative said, "They get a doctor in a few seconds if she's unwell. The manager is very good."

We observed people using their bedrooms and communal areas. These included a lounge area and the dining room which was spacious. There was space for people to take part in activities and there was a garden which people used. There was access via a passenger lift to the first floor. People were observed moving around the home and most areas had ramped access for those with mobility needs. There was a change in floor level in the hall corridor where a ramp was used to assist people. The ramp was short and of a steep gradient which made it less easy for people with mobility needs to negotiate than a lower gradient. We raised this with the registered manager who said this had not been any issue for any people. The provider may, however, wish to consider an assessment of the premises by suitably qualified persons, such as an occupational therapist, regarding people whom have mobility needs.

Equipment was available for people who were living with dementia to interact with. This was displayed on the wall in the dining room so people could interact and use the equipment as they wished and without staff supervision. People were able to bring their own belongings to the home and we saw examples of this in people's rooms which were personalised.

Good

Is the service caring?

Our findings

People and their relatives said the staff treated them with kindness, consideration and in a manner which made them feel valued. For example, one person said, "They are very, very good. They're pleasant to talk to. They do what I ask them to do. They are very good to me. They treat me as if I paid to go to a £1000 place."' Another person said, "They couldn't be kinder, even the young men. We all get an arm round your shoulder and a hug. They couldn't be kinder. They're absolutely lovely." A community nurse described the staff as, "really friendly," and that the staff, "really, really care."

People's care plans were individualised and staff knew the importance of treating each person according to the person's preferences and needs. Training in communicating with people was provided for staff and care plans included details of how staff should communicate with each person including those people living with dementia. Details of people's background had been assessed and recorded so staff had access to information about people's life history so they could get to know people better. Personal preferences such as daily routines were recorded and showed people had a choice in how they spent their time. Care plans included people's views which were incorporated into their care plan. The care plans also showed people or their relatives had signed to agree to their care. The registered manager showed a commitment to promoting people's rights to a fulfilled life. This included people's rights to be independent and to have personal and sexual relationships in old age. This had been discussed with the staff and guidance obtained from a 'think tank' dedicated to addressing issues of longevity and ageing.

We noted one bathroom did not have a privacy lock, which is included in the Safe section. The staff promoted people's privacy and dignity. The importance of this was assessed when new staff were recruited. Staff training included person centred care and subjects such as, 'the person perspective.' Staff demonstrated they valued people and promoted people's rights. For example, one staff member said, "It's their home, not ours. I am committed to my work. I value the residents." Another staff member said, "Person centred care is important to people and the families. We aim to provide the best quality of life. We do not label people and are caring and individualised." We observed staff treated people well. There was rapport between people and staff who chatted and laughed together. Staff were polite and showed they cared about people. Staff spoke to people and made good eye contact when they supported them with the meal. People told us their privacy was promoted. When we asked people about this they said, "Yes, they always knock on the door," and, "Definitely, yes. They always knock on the door, wherever you are." A relative replied, said, "Totally, always." We observed staff supported people in a discreet way which promoted people's privacy. People were able to exercise choice in whether they received care from male or female staff, which was recorded in the person's care plan.

Relatives said they felt supported and welcomed by the staff. We observed a relative having a meal with their spouse. One relative said about being welcomed, "Oh yes. A cup of tea comes before I sit down. They all know me." Another relative said, "They all know me as [first name] and I eat tea here quite often so I can stay with [relative]. It's lonely for me at home too, there's no one there."

Good

Is the service responsive?

Our findings

People received personalised support which met their needs. People said the staff took account of their preferences and this was reflected in their individual care plans. Care records showed care needs were assessed in detail and there were corresponding care plans with details about how staff should support people. These covered support with personal care, assistance with mobility and the assessment and prevention of falls. The care plans were individualised to reflect person centred care based on each person's needs and preferences. Staff told us of the importance of treating people as individuals and of being person centred. Where incidents had occurred there was an evaluation and a review to adjust any support the person needed. Details about mental health needs such as emotional support and how to support people who were living with dementia were recorded. Care plans were also reviewed and updated each month; these involved people and their relatives where this was practical. We observed staff supported people on an individual basis at meal times. People were supported to be independent and staff intervened when this was appropriate.

Details of people's background was included in the care plans and showed people and their relatives were involved in this. Each person had a life story book which was compiled with the person and their relatives to show the person's background and lifestyle they had before they moved into the home.

People said they were able to take part in activities, which they enjoyed and that these involved contact with the local community and people's families. For example, one person said, "A lady comes in with her guitar and they join in. A man comes too, they love him. They know a lot of songs even if they have dementia, it's amazing. A man comes and they lift things, for exercise. They have a garden fete in the summer. They have a bouncy castle for the children, they enjoy seeing the children."

The service employed activities coordinators which covered five days of the week. There was an activities programme displayed which was in pictorial format for easier understanding by those living with dementia. The activities included singing, playing music, a Pet as Therapy dog and exercises. People referred to these activities and said they enjoyed them.

Records demonstrated people were able to benefit from activities on a group and individual basis. Each person had a record of the activities they had attended which included music and movement and art work. There were photograph displays of activities people had taken part in such as parties to celebrate Hallowe'en, Valentine's day and Easter. Displays of art work created by people were displayed in the home. We observed staff supporting people to make use of the garden on a sunny day.

We observed the activities coordinator looking through a scrapbook with one person which had photographs of the home's summer fete and chair exercises. We observed the activities coordinator helped women with their make-up, which they enjoyed and the women chatted about their lives and families. This induvial approach to activities with people was beneficial to people who responded positively. The activities coordinator demonstrated warm relationships with people and knew them well.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. One person had a scribe board which they carried with them so staff could communicate with them. Care records included details about people's communication needs. Staff were also supported with training in how to communicate with people who were living with dementia. Notice boards and signs were used to communicate with people who were living with dementia. These included the menu plan and activities programme in pictorial format.

The provider listened to and responded to any complaints. The complaints procedure was displayed so people and their relatives could see what to do if they wished to complain. People and their relatives said they knew what to do if they had to make a complaint. The provider informed us that three complaints had been made in the 12 months before the inspection. There was a record of each complaint, whether it was made in writing or verbally. Each complaint had been looked into and there was a written response to the complainant including an apology from the provider if this was applicable. The provider had a Duty of Candour policy which is required by Regulation 20 of the Health and Social Care Act 2008 and outlines what providers must do when things go wrong and an apology made when applicable.

We looked at how the service supported people at the end of their life. A community nurse said the staff provided good end of life care to people, "They are always really good with end of life care. They are very caring and the families are happy with the care." Two staff had completed a training course at a local hospice in end of life care, 'the six steps to end of life care.' The course is nationally recognised and requires staff to revalidate it each year. The registered manager told us that a further two staff were due to start the course. The home was also recognised by a local hospice as providing end of life care which was also revalidated each year as achieving a certain standard in the specialism of end of life care. At the time of the inspection there were no people in receipt of end of life care.

Requires Improvement

Is the service well-led?

Our findings

The provider's governance system had not ensured the service was adequately assessed and monitored regarding quality and risks to people and others. The premises were poorly maintained in places and presented risks to people, yet the monitoring of the safety of the premises had not identified and acted on these. This included regular visits and checks on the service by a group manager. We found damaged furniture and fittings and exposed hot pipework adjacent to a bed in a person's bedroom, which meant the person was at risk of being burnt. We raised this with the registered manager at the time who gave assurances this would be acted on. However, this had still not been addressed more than a month after the inspection. Adequate measures had not been taken regarding the prevention of infection as there was a lack of a washbasin in two communal toilets and the kitchen was neither clean nor well maintained.

The medicines procedures were audited but the registered provider had failed to identify the shortfalls we found in the handling and recording of a controlled medicine, which placed the person at risk of not receiving their medicines as prescribed. Records for controlled medicines had not been properly maintained. The provider did not have specific procedures for the administration, handling and recording of controlled medicines which met the guidance of the Royal Pharmaceutical Society.

The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager who was aware of her responsibilities and was committed to improving the service although we noted there were areas where action was needed to make improvements. The registered manager had attained qualifications in care and management. The registered manager promoted a culture whereby staff were encouraged to achieve a good standard of training, which was monitored. There were examples of staff being provided with education in matters of equality and inclusion for older people as well as in specific care procedures.

The service had a management structure and lines of accountability for staff to follow. There was a registered manager and a deputy manager plus a head of care who oversaw the senior staff and care staff. The staff said they were well supported and described the management as approachable. Staff had opportunities to discuss any issues about the service either directly with their line manager or at the staff meetings. Staff said they were listened to and action taken when needed; this reflected a culture of equality and inclusion of its staff. There were separate meetings of the management team regarding the operation of the service. There was oversight of care staff by supervision, appraisal and direct observed assessment of their work.

A number of audit checks were carried out regarding safe care and treatment, nutrition, incidents and accidents as well as staff training. Care plans were audited and people and their relatives were involved in reviews of care. We saw people and their relatives' views were taken account of and these were clearly

recorded, which reflected a culture of including people in decisions. The provider used surveys to obtain people's and their relative's views of the service and there were action plans of how the staff would be addressing any suggestions or issues raised. Relatives felt included in the home and in the care of their relative living at the home. The views of outside agencies and professionals were also sought. Health care professionals told us they had good working relationships with the staff to ensure a coordinated approach to care. A community nurse said they had "really good communication" with the deputy, that staff were grateful and accepting of advice and support, and, when issues were raised these were fully addressed. Another health care professional said care staff followed any advice given, made appropriate referrals and had good liaison with health care services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (d) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not adequately assessed, monitored and improved the quality and safety of the service including action to mitigate against risks. Records were not always complete and contemporaneous. Regulation 17(1) (2) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensured the premises were well maintained and fit for purpose. adequate The premises did not promote adequate prevention of infection and not all areas were clean.. Regulation 15 (1) (a) (c) (d) (e) (2)

The enforcement action we took:

The provider had not ensured the premises used by people and others were safe to use.
WN to be issued