MDJ Homes Limited

Shaws Wood Residential Care Home

Inspection report

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21 October 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 19 and 21 October 2016. Our inspection was unannounced.

Shaws Wood Residential Care Home offers accommodation and long term care and support to up to 39 older people. Some people were living with dementia, some had mobility difficulties, sensory impairments and some received their care in bed. Accommodation is arranged over two floors. There is a passenger lift for access between floors. There were 38 people living at the home on the day of our inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our previous inspection on 04 December 2014 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service as good overall and requires improvement in well led. We asked the provider to take action to meet the regulations.

At this inspection, people gave positive feedback about the service. People felt safe and well cared for.

The provider did not follow safe recruitment practice. Essential documentation was not available for all staff employed. Gaps in employment history had not been explored to check staff suitability for their role.

Some areas of the home smelt strongly of stale urine. Effective cleaning methods were not in place to control infection.

People were at risk of unsafe care because there had been times at night when people had been unattended on the ground floor for short periods of time, whilst staff supported the staff upstairs during emergencies.

There was a call bell system in place which people could use if they required help and support. During the inspection we observed the call bell system ringing for long periods of time. There was an intermittent issue with the call bells where if a person pressed their call bell upstairs it was not sounding the alarm upstairs. We observed this to be the case and observed staff working downstairs ringing the staff upstairs to let them know that the call bell was sounding. We made a recommendation about this.

We checked the medicines records and found that there were gaps and inconsistencies in the medicines administration records (MAR) for people in relation to people's topical creams. We made a recommendation about this.

Some staff had not had regular supervision with their line manager. Two staff had not had a formal

supervision for 16 months and one had not had a formal supervision for 17 months. Staff who had worked longer than year had not received an appraisal. We made a recommendation about this.

People were given information about how to complain and how to make compliments. Complaints had not always been dealt with appropriately. We made a recommendation about this.

There were quality assurance systems in place. The registered manager carried out regular checks on the home. The audit systems had not identified the issues with staff recruitment records and topical medicines records. We made a recommendation about this.

People's information was mostly treated confidentially, however one small office area upstairs did not have a door which meant that anyone could access the daily records held in there as well as information on the wall. We made a recommendation about this.

Staff had received training relevant to their roles. Staff were supported and encouraged to complete work related qualifications.

Staff had a good understanding of what their roles and responsibilities were in preventing abuse. The safeguarding policy gave staff all of the information they needed to report safeguarding concerns to external agencies.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications for some people.

Meals and mealtimes promoted people's wellbeing, meal times were relaxed and people were given choices.

People received medical assistance from healthcare professionals when they needed it. Staff knew people well and recognised when people were not acting in their usual manner. People at the end of their life received suitable care and treatment and were involved in deciding what that would be and where they wanted the care and treatment to take place.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time and were complimentary about the care their family member's received.

Staff were cheerful, kind and patient in their approach and had a good rapport with people. The atmosphere in the home was calm and relaxed. Staff treated people with dignity and respect.

People were encouraged to take part in activities that they enjoyed. People were supported to be as independent as possible.

People's views and experiences were sought through review meetings and through surveys.

We found two 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?

Requires Improvement

The service was not consistently safe.

The provider had not always followed safe recruitment practices.

Infection control systems were not robust. Cleaning in some areas of the home did not remove the odour of urine.

Medicines had not been appropriately managed and recorded. Topical records did not always show that people had received their medicines as prescribed.

Risk assessments were clear and up to date so staff had clear guidance in order to meet people's needs.

Staff had a good knowledge and understanding on how to keep people safe from abuse.

Enough staff had been deployed to meet people's needs during the day. Call bells were faulty which meant that there were some delays to people's needs being met.

Is the service effective?

Good

The service was effective.

Staff had the essential and specific training and updates they needed. Staff said they were supported in their role.

Staff had not always received supervision and appraisal.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place.

People gave us mixed reviews about the food. People had choices of food at each meal time.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring.

The staff were kind, friendly and caring towards people and their relatives.

People were supported to maintain relationships with their relatives and friends. Relatives were able to visit at any reasonable time.

Staff were careful to protect people's privacy and dignity and people told us they were treated with dignity and respect. People's information was not always treated confidentially.

Is the service responsive?

Good

The service was responsive.

Care plans detailed people's important information such as their life history and personal history.

People were encouraged to participate in meaningful activities, which were person centred and included community trips.

People and their relatives knew how to raise concerns and complaints. Complaints management was not always effective in relation to dealing with concerns about missing personal items.

People and relatives had opportunities to feedback about the service through meetings and surveys.

Is the service well-led?

Good

The service was well led.

The management team and provider carried out regular checks on the quality of the service. Action had been taken to address identified shortfalls. The audits and checks carried out had failed to identify the quality concerns within the service in relation to staff recruitment records and topical medicines records.

The service had a clear set of values and these were being put into practice by the staff and management team.

Staff were not always positive about the support received from the management team.

Shaws Wood Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 21 October 2016 and was unannounced.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we sent the provider a Provider Information Return (PIR). However this was not received by the service. This is a form that asks the provider to give some key information about the home, what the service does well and improvements they plan to make. We reviewed previous inspection reports, actions plans and notifications before the inspection. A notification is information about important events which the service is required to send us by law. We also reviewed information of concern that we had received.

We spent time speaking with 11 people, five relatives and two visitors. We spoke with nine staff including care staff, senior care staff, the cook, the registered manager and the head of operations. We also spoke with two further staff outside of the inspection visit.

Some people were not able to verbally express their experiences of living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas.

We contacted health and social care professionals including the local authorities' quality assurance team and care managers to obtain feedback about their experience of the service. We received feedback from Healthwatch Medway and a facilitator for end of life care.

We looked at records held by the provider and care records held in the home. These included eight people's care records, medicines records, risk assessments, staff rotas, five staff recruitment records, meeting minutes, quality audits, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including some policies, quality assurance documents and training records. The information we requested was not sent to us in a timely manner because the scanner and photocopier had broken during the inspection and needed replacing. We received the information between 28 October and 02 November 2016.

Requires Improvement

Is the service safe?

Our findings

People told us they received safe care. People told us about equipment they used to mobilise around the home. Comments included, "They [staff] know what they are doing and don't rush me"; "I know if it's not mine [Zimmer frame] because it is not comfortable like this one"; "I like living here, I have friends to chat to and I do have visitors come to see me". The girls [staff] are lovely and help me when I need it"; "It is ok living here there are people around but I do like my own company"; "I am happy enough living here. I am fiercely proud and independent and like to do all things for myself while I am able. I do not have help with personal things as I wouldn't want that but they know that and that is fine"; "There are plenty of people around"; "I am happy living here there are always people around and they do help me when I need them to"; "it was ok living here I do need help with washing and dressing now and the staff are ok and help me without rushing me". They do check on me and see if there is anything I need as I prefer to stay in my room"; "Makes me feel safe as they know what they are doing" and "It's reasonable living here, it's an average sort of place".

Relatives gave us mixed feedback about the service their family members received. Comments included, "The staff are fine and do take care of my relative as she now needs quite a lot of help as she is quite elderly now. There are enough people around and there is a call bell if it is needed"; "There seem to be lots of people [staff] around. Everyone sitting here seems quite settled and happy" and "There are always staff around and they speak and make me feel welcome sometimes with a cup of tea".

Recruitment practices were not always safe. Four out of five staff recruitment files showed gaps in employment which had not been explored. Gaps ranged from seven years to 35 years. The provider had not carried out sufficient checks to explore the staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. References had been received by the provider for all new employees. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff employment files showed that references had been checked.

This was a breach of Regulation 19 (2)(a)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean and tidy, however several areas of the home smelt strongly of stale urine. The flooring had been replaced on the ground floor, to enable staff to clean effectively. However, the smell of urine was strong in places. One staff member told us that the service had difficulty, "Keeping the place clean as urine is a problem and it is difficult to keep up with". A relative told us, "Cleanliness is hit and miss, the odour [referring to the odour of urine] is always present". We spoke with the head of operations about this and they told us that this was because the steam cleaner had broken and recently been replaced. They explained that the supplier of the new steam cleaner was scheduled to visit the home on the 20 October 2016 to demonstrate how to use the new equipment. When we returned to the home on the 21 October 2016 this training had not happened as the supplier had not turned up. Whilst we observed staff mopping up after spillages and where people had been incontinent of urine. However this cleaning method was not adequate

to remove the odour, which meant effective cleaning methods were not in place to control infection. Some bathrooms and toilets within the home did not have pedal bins. One toilet contained a bin with a clinical waste bag in which not foot operated which meant that people had to touch the bin lid to open the bin which increased the risk of contamination.

The staff who worked at night gave examples of times that they had to leave one floor with no staff at all which meant that people were at risk of injury or harm because of lack of effective supervision. This had happened on several occasions when a person living on the upper floor had fallen and injured themselves and the staff member had called for help. Both staff working on the ground floor had gone to their aid to assess the situation and agree what action needed to be taken. This left people unattended on the ground floor for short periods of time.

The failure to ensure care was delivered in a safe way was a breach of Regulation 12 (1)(2) (a)(b)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable numbers of staff on shift to meet people's needs during the day. Agency staff were used when required to fill vacancies and staff absence. The provider had a dependency tool in place to check that staffing levels were appropriate to meet people's needs. Records evidenced that these had been regularly updated and reviewed.

There was a call bell system in place which people could use if they required help and support. During the inspection we observed the call bell system ringing for long periods of time. The registered manager explained that there was an intermittent issue with the call bells where if a person pressed their call bell upstairs it was not sounding the alarm upstairs. We observed this to be the case and observed staff working downstairs ringing the staff upstairs to let them know that the call bell was sounding. This was labour intensive. One staff member told us this issue with call bell had been ongoing for several months. One relative told us that they felt there was not enough staff on duty at weekends because "It was difficult to find staff to talk to at weekends. The call bells go off a lot and there are long delays to getting them answered". On one occasion we also observed that one person who lived downstairs had pressed their call bell. The call bell was ringing downstairs for approximately 10 minutes until the handyperson visited the person in their room to answer their call.

We recommend that the provider engages a suitable and qualified person to ensure the call bell system works effectively.

People were protected from abuse and mistreatment. Staff had completed safeguarding adults training. The staff training records showed that 40 out of 41 staff had completed training. Staff understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager knew how to report any safeguarding concerns.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. Risk assessments and care plans had been reviewed regularly. Records showed that when people's circumstances changed or there had been an accident or incident, risk assessments had been updated to reflect this. Risk assessments

relating to people's pressure areas were completed and suitable equipment was put in place to reduce the risks, such as pressure relieving mattresses and cushions.

Accidents and incidents were appropriately recorded and monitored. Completed forms showed that the registered manager checked these and took action when required. Referrals had been made to the falls clinic for people that had fallen a number of times. The registered manager produced a monthly report for the head of operations and the provider which enabled the management team to identify trends.

We observed a medicines round. This was carried out by a staff member who had undergone relevant training. The staff member wore a tabard with 'Medicines round do not disturb'. The medicines round was being shadowed and observed by the head of care who was carrying out a medicines competency assessment on the staff member. Medicines were administered safely during this round. Accurate records were made of the medicines administered. People who required creams to be applied during the middle of the day were supported to have these creams applied in their own rooms to ensure their privacy. We checked the medicines records for the month and found that there were gaps and inconsistencies in the medicines administration records (MAR) for people in relation to people's topical creams. We found one error where two staff had signed to state that a controlled drug had been disposed of, however the medicine was not listed in the medicines returns records. We checked the medicines in stock and found that people had received their tablets as prescribed. Where people had not received their medicines, an entry had been made on the MAR to evidence why they had not; for example when a person had a hospital appointment.

We recommend that registered persons follow good practice guidance in relation to medicines records.

Medicines were stored in the home's medicines room. The medicines room was securely locked. The room temperature was recorded twice a day, and these records were up to date. This meant that the home could be sure that the room temperature was appropriate for the storage of medicines.

The premises were generally well maintained and suitable for people's needs. Outside there was a well-kept paved garden. There were bright flowers and shrubs in a number of containers and seating. Bedrooms had been decorated and furnished to people's own tastes. Fire extinguishers were maintained regularly. Fire alarm tests had been carried out. Staff confirmed that these were done weekly. Records showed that emergency lighting had also been tested regularly. Any repairs required were generally completed quickly. We observed that the areas of the home which had been assessed as unsafe for people to enter without support, such as the laundry room, kitchen, sluice rooms and cleaning stores and stairwells were locked and secure. Gas and electric installations had been checked. Hoists and slings had been serviced.

Good

Is the service effective?

Our findings

People told us they were encouraged and supported to be as independent as possible. People gave us mixed feedback about the food. Comments included, "The food is alright it is usually hot and there is enough of it, you can always ask for more"; "The food is average but it's hot so what else can I say" this person went on to say they do "Enjoy my food". Other comments made were; "The food is ok but I don't have a big appetite and when I don't eat it all I feel guilty" and "The food is ok. It is basic home cooking with things we know".

Relatives told us their family members received effective care. They detailed that staff were responsive to changes in their family member's health and took action when required. Relatives told us their family members received good food. Comments included, "Food looks good, there is good choice for them. Mum is diabetic, they monitor her blood sugar and provide appropriate food"; "Mum's health needs are well met" and "Food always looks and smells very appetising, staff know mum and give small portions and give her options of other foods when she is refusing".

Staff had received training and guidance relevant to their roles. Training records evidenced that all staff had attended fire, moving and handling, health and safety and control of substances hazardous to health (COSHH). Records showed that 35 staff had attended Mental Capacity Act (MCA) training, 40 staff had attended food hygiene training, 31 staff had completed diabetes training and 21 staff had attended end of life care training. The training records evidenced that staff were offered opportunities to complete additional training in subjects that they were interested in which related to people's health care needs. The facilitator for end of life care said, "I understand most of the staff have had training for end of life but I have been in and given bespoke sessions to the carers when requested". Records showed that 21 care staff had attended training in this area which gave the staff team a good understanding of providing care for people who are at the end of their life.

Thirty five staff had completed dementia awareness training. We observed staff communicating and helping people with dementia. They recognised when they were distressed and disorientated and helped them to find a purpose. One person frequently asked staff to help them find their mum, staff tactfully and sensitively explained that their mum wasn't at the home and helped them to understand where they were. On one occasion the head of operations helped the person by offering them some paper and a pen so they could write to their mum instead. This reassured the person immediately and they happily involved themselves in the task. Healthwatch told us, "Shaws Wood have worked with a university specialising in dementia environments to increase the dementia friendliness of the home. If residents require a visual prompt to identify their room door a suitable picture will be identified which can act as a memory prompt and then placed on the residents door in order for ease of recognition".

Staff told us that they had an induction when they started work. This included shadowing experienced staff providing care and support, reading policies and procedures, completing the Care Certificate (which includes completing course work and observations of practice) and undertaking training. Staff had been supported to undertake qualifications relevant to their role, such as diplomas and National Vocational

Qualifications (NVQ's) in health and social care.

Most staff told us they received regular supervision. Some staff told us they had not. We checked the registered managers' supervision matrix which showed that some two staff had not had a formal supervision for 16 months and one had not had a formal supervision for 17 months. Staff who had worked longer than year told us they had not received an appraisal.

We recommend that the registered manager reviews the supervision and appraisal process.

There were procedures in place and guidance was clear in relation to Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. Staff were knowledgeable concerning the need to seek consent when providing care for people. Staff told us that they helped people to be as independent as possible and they helped people to make decisions and choices by showing them the options when dressing, activities and with eating. One person said, "The girls [staff] are kind and polite and don't rush me when they help me to get washed and dressed and they always ask me what I would like to wear today". We observed staff doing this in practice. People who were at the end of their life were supported to make decisions and choices about their care, treatment and arrangements after their death. The facilitator for end of life care told us, "I feel the residents are very much supported and involved in making decisions and advance care plans for their end of life care. The home adopts the preferred priorities of care plan wherein wishes and concerns are documented. I have attended residents meetings and advance care plans and resuscitation has been discussed and I am requested to visit to discuss care needs for residents and their concerns around end of life care planning whenever needed. The home always refers".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Systems to monitor DoLS authorisations were robust. Applications were completed by he registered manager and then submitted to the local authority. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People had choices of food at each meal time and chose to have their meal in the dining room or their bedroom. The registered manager had recognised that one person was not enjoying eating their meals with others, incidents of aggression had escalated. The person was supported to eat their meal in the lounge away from others. They were happy and calm and ate their meals without further incident. People were offered more food if they wanted it and people who did not want to eat what had been cooked were offered alternatives. Hot and cold drinks were offered to people throughout the day to ensure they drank well to maintain their hydration. One relative gave us an example of their family member refusing all drinks in the hot weather in the summer; they explained staff tried everything to get them to drink including ice poles from the freezer. The facilitator for end of life care detailed that "The staff are encouraged to offer food and fluids as tolerated to the residents right up to end of life. No food or fluids are withheld. Advice is often sought around this either from myself or the GP/SaLT [Speech and language therapist] or dietician". People were offered snacks such as biscuits, cake and fruit during the day. People who received their care in bed received appropriate support to eat their meals. We observed staff chatting to a person whilst assisting the person to eat; they were kind and considerate throughout. People who ate their meals in the dining room ate in a friendly and relaxed atmosphere, there was plenty of conversation between people and staff.

The menu was clearly displayed on the wall outside the dining room downstairs and in the upstairs dining

room, this was available in written and pictorial form to help people make their choices. The pictures looked appetising. On 21 October 2016 the picture showed that fish and chips were on the menu, but we observed fish fingers and chips were cooked and served. This had misled some people with their choices. We observed staff offering one person more food and the person said, "No thank you I like proper fish".

Food was appropriately stored within the kitchen. Staff who worked in the kitchen were suitably qualified and knowledgeable about how to meet the nutritional needs of the people who lived at the home. There was plenty of food in stock. This included fresh fruit and vegetables, meat, tinned, dried food, frozen and dairy foods. Special foods had been purchased for people with a specific dietary requirement such as diabetes, gluten free diets and vegetarian. The chef had a
good understanding of how to fortify foods with extra calories for people at risk of malnutrition. Nutritional needs and food likes and dislikes had been recorded within people's care files. The chef had copies of the relevant information and used these to provide the foods people liked and needed. Checks were made concerning the serving temperature of food to make sure it was properly heated.

There was a good system in place to monitor people's weights. The registered manager checked the weights on a monthly basis and took action when concerns were noted. The weights records showed that every person had been weighted monthly.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Pain assessments had been carried out and evidence showed that people had received pain relief when it was required, these had not been dated. Staff had sought medical advice from the GP when required. Referrals had been made to SaLT, falls clinics and to the district nurses when people who needed it. Records demonstrated that staff had contacted the GP, the hospice, ambulance service, dementia specialists, physiotherapists, hospital and relatives when necessary. On the day of our inspection people were supported to attend hospital appointments by staff and hospital transport was provided. Some people were supported to attend appointments by their relatives. District nurses attended the service to provide people nursing care. A GP arrived at the service to visit a person was not feeling well. One person told us they had been unwell the day before we inspected. They said, "They have been very kind and taken care of me and I do feel a lot better today". Specialist nurses were involved in relation to Parkinson's disease and diabetes. People had seen an optician on a regular basis to check the health of their eyes. Where people had pressure areas, appropriate action had been taken. Body maps were used to show a clear record of the wound and these had been updated to show how the wound was progressing.

People who were at the end of their live received good quality care and support to make sure they were involved in the decisions about the care and treatment they received and where they wishes to receive it. They received support from the palliative care team in setting up anticipatory medication. The facilitator for end of life care stated, "The home is one of the few residential homes who are very prepared to care for their residents approaching end of life and go the extra mile, they are supported with clinical care from the district nurses and myself. They refer in a timely and prompt manner not waiting for a crisis and when possible prevent unwanted hospital admissions". Excellent systems were in place to monitor and maintain people's health.

Good

Is the service caring?

Our findings

People gave us positive feedback about the care and support they received from the staff. Comments included, "People [staff] are very kind, they talk to you and knock on your door before coming in"; "They are nice and kind here"; "You can ask for anything if you want something and they are very kind and knock on the door to see if we are ok"; "People [staff] are very kind and let me do things my way"; "I like it here they are so nice to us"; "People [staff] are nice" and "The girls [staff] are very kind and do look after me".

We observed staff were kind and caring and took time to chat with people. We also observed that staff reassured people when they became distressed or agitated; a person requested that they wanted to visit their home, the member of staff explained that this was difficult at the time and offered a cup of tea and a chat to see how they could see how this could be managed. The person was happy with this and the situation was immediately diffused. Another person was feeling cold; a member of staff found them a cardigan and a blanket and recognised that the person had become uncomfortable in their chair. The staff member encouraged the person to reposition themselves by explaining how to do this. There was a lot of laughter and encouragement whilst the person was repositioning. The person was supported to be more comfortable.

Relatives told us that their family members received good quality care from friendly, kind and caring staff. Comments included, "Staff are absolutely lovely, they treat her like she's part of their family. They knock on her door before entering" and "I'm quite happy, the atmosphere here feels so caring, it makes you feel it is a special place. A warm and happy atmosphere" and "the care staff are fantastic, they treat mum incredibly well. The way they speak to her is very good". A visitor told us their friend was "Extremely comfortable and looks peaceful" they went on to say that when they had arrived the staff member entered their friends room and gently woke them up to explain that they had visitors.

Cleaning staff and maintenance staff were observed interacting with people. They had a good manner and clearly knew people well. The handyperson was observed supported a person to locate the dining room at lunch time when they appeared to be lost. A member of cleaning staff told us "I see and speak to them [people] every day, it's nice to be able to have just a little chat. I can keep an eye on them. If I thought they were unwell I would tell someone. The care is very good here". Staff knew people well, we observed discussions about likes and dislikes and staff asked how people's relatives were. Throughout the inspection there was laughter, jokes and chatting between people and staff. The facilitator for end of life care said, "When staff are spoken to about the resident they know them well" and "staff are always attentive to the resident's needs and friendly".

Staff knocked on doors and treated people with respect and dignity. We observed staff knocking on doors and asking permission to enter. Staff crouched down to ensure they were at the same level as the person when talking with them. People being cared for in bed were approached gently by staff, staff explained who they were and offered gentle prompts to encourage interaction. Staff described how they maintained people's privacy whilst supporting them with their personal care needs, such as ensuring that doors were closed, people were covered up and curtains were closed. People told us that staff respected their

independence and let them do things for themselves without taking over. One person said, "They let me be independent as I don't want or need any help but I would feel happy to ask if I did need anything".

People's care plans detailed their life histories and important information which helped staff engage and respond to their individual needs, this included information about where they had lived, who their relatives were, important dates and events and what people's favourite things were. People's care plans clearly listed the care and support tasks that they needed. Daily records evidenced that care had been provided in accordance with the care plan.

Relatives told us that they were able to visit their family members at any reasonable time and they were always made to feel welcome. Relatives told us they always felt welcome to visit. Comments included, "I always feel welcome when I visit, that is usually twice a week. There are always people around and although they are busy they do stop and chat to people as they pass by"; "They [staff] are very friendly and made me feel quite welcome"; "The staff are fine and do take care of my relative". Some visitors told us, "We are always welcomed and we are given private time".

Staff had a good understanding of the need to maintain confidentiality. People's information was mostly treated confidentially, however one small office area upstairs did not have a door which meant that anyone could access the daily records held in there as well as information on the wall. Personal records were stored securely in the office to make sure they were accessible to staff. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

We recommend that registered persons review the security arrangements for the upstairs small office area.

The handovers between staff going off shift and staff coming on shift were documented. This included information about any medical concerns and the emotional wellbeing of people who lived in the home. This ensured that information was passed on and documented appropriately.

People's religious needs were met. The registered manager and staff had identified that people missed visiting church services. Whilst they had opportunities to take part in church services that took place within the home, people did not have an opportunity to mix with the wider community. The activities staff had engaged with a local church to discuss this. The church then developed a dementia friendly church service with a church in the community, the church encouraged people to attend and take part in a service and mix with other church goers. During the inspection a small group of people attended the church for the service.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. Everyone told us there were activities on offer which they could take part in if they wished. Comments included, "I don't join in the activities as quite honestly I prefer to watch the television with my favourite programmes. I get up and go to bed when I like and that suits me"; "I am not interested in any activities as I preferred my own company" and "I enjoy it when a member of the church visits". They went on to tell us that the activity for that afternoon was visit to a local church "Which I will be going to. I don't usually join in the activities but I do talk to people at mealtimes". We observed they did go along with four other people. We observed staff responding to people's requests. Staff gave each person time and did not rush anyone. One person chatted to a member of staff about where they had lived and their life during that time. The staff member was responsive and took time to listen and interact.

Relatives gave us mixed feedback about how responsive the service was to them and their family members. All of the relatives knew who to go to if they had any concerns or complaints. Relatives shared that they had made complaints about the service received. Relatives told us their family members had enough to keep them occupied. Comments included, "Mum has enough to do, sometimes she refuses to do activities they provide"; "With activities they really have to persuade her, she goes to the day centre and to activities in the dining room. Staff respect mums decisions and wishes, they are pretty switched on".

People took part in a number of activities based on their individual preferences. There were two activities coordinators employed to arrange and develop activities for people. Activities were planned for the fortnight ahead and advertised on the communal notice boards. One activities coordinator told us; "Families join us for some activities too". They explained that some of their role involved sitting with people "Talking, reassuring and praying". During our inspection activities included, a trip out into the community for a church service, singing and motivation activities. Activities at the home included dominoes, bingo, ball games, singing, motivation, music for health, art, hand massage, a staff member brought their dog in for people to pet. A relative also brought their dog in. The home had links with local schools which enabled people to interact with children. The children had performed recorder concerts. A local nursery school had arranged to visit the week after our inspection to carry out a harvest festival. The activities staff told us about the different types of religious services held. Carol singers and concerts had taken place. The activities staff had ensured that people who received care in bed were involved by ensuring carols were sung outside each person's bedroom door. The service had access to a number of games and activities which were owned by the provider and used in a day service which was run from the lower ground floor of the home. Some people attended the day service. People were encouraged to use the garden when the weather was good, one person told us about the plants they had planted in the raised beds in the garden for all to enjoy. A hairdresser visited the home twice a week.

People were supported to take part in activities in the local community. The activities team coordinated outings to shops, pubs and garden centres.

Care plans contained information about people's life history, preferences, likes and dislikes. One person's

care plan did not detail that they had missing teeth. We observed during the inspection that this caused the person some difficulty eating food that required chewing. The person told us they were having difficulty. They had not reported this to staff. We spoke with the registered manager about this and they arranged for a staff member to observe the person and discuss with them what help they may need. The registered manager agreed that they needed to update and amend the care plan with the information.

People knew who to complain to if they were unhappy. One person said, "If I do have a problem I will say something". Another person told us they were, "Unhappy with problems dealt with by management". The provider had a complaints policy and procedures which included clear guidelines on how and by when issues should be resolved. It contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The complaint procedure was displayed in the communal areas. Relatives knew they could complain to the registered manager if they needed to. There had been three formal complaints about the service within the last 12 months, the complaints had been acknowledged and investigated within the provider's timescales. The outcome of complaints had been communicated and actions taken to address them had been taken. Records showed that the registered manager had worked with relatives to develop a new care plan in one instance, following a meeting. One relative told us about a complaint that they had made to the service about missing personal items, they were very upset and tearful about the missing items and felt that the complaint had not been properly investigated they had not received an outcome letter. We checked the complaints record and found that the complaint was not recorded. We spoke with staff about what they would do if relatives complained that personal items went missing, they all explained that they would search for the items, leave a note for staff within the handover records so that staff on the next shift could continue to look for the items. Some staff told us they would record the missing items and some said they wouldn't. One staff member said, "I haven't heard that it needs to be recorded". It is clear that the complaint from the relative was not recorded as such and had been missed, which meant that the items were still missing and the relative remained upset and unhappy.

We recommend that registered persons review complaint handling procedures.

The service had received lots of compliments from relatives from observations when they have visited. These included letters and thank you cards. Comments included, 'You were wonderful to her, and we could not have asked for more'; 'Thank you all so much for the care you showed looking after our dad'; 'Thank you all so much for the loving attention and care you gave my mum. Knowing the kindness and warmth you gave made me feel very grateful'. One relative had written to thank the staff for helping them celebrate their wedding anniversary with their family.

People attended meetings to discuss their opinions of the service and get updates on changes to the way the service was running. The most recent meeting which was held on 14 March 2016 gave people the opportunity to feedback about areas they felt needed improvements such as food, entertainment, personal items going missing from bedrooms and call bells taking a long time to be answered. Previous meeting records showed that people's suggestions and feedback had been listened to. For example macaroni cheese was requested by people to be put on the menu, this had been acted on. Relatives were also able to meet with the management team to discuss their feedback, the most recent meeting had been held on 15 October 2016. The meeting records showed that seven people's relatives attended the meeting. Items discussed were the need for naming clothing and laundry, home improvements such as new flooring, reduction of odour, plans for festive events such as raffles. The management team had shared with relatives that care plan reviews were due and had offered to arrange for the end of life care facilitator to come to a future meeting.

The provider carried out an annual survey of relatives and friends. The surveys had just been sent out and had a deadline of 28 October 2016. The head of operations was in the process of collating the survey responses received so far. We viewed some responses most of which were positive. Comments written included, 'I am happy with the care given to my mother'; 'We remain assured that mum gets very well cared for at the home'; 'I do feel that communication is good although I have raised concerns and had to chase things'; 'I feel [person] is very well looked after'. One comment had scored the home as average for communication and had given examples of when communication had not been good. One relative told us that although the survey could be completed anonymously, there was nowhere to place the completed forms when they were being dropped off which meant that relatives handed them to staff. This meant they could be identified. We spoke with the head of operations about this and they agreed to put a better system in place.

Good

Is the service well-led?

Our findings

At the last inspection we found a breach in regulation relating to lack of effective systems in place for monitoring the quality and safety of the service and inaccurate and incomplete records. We asked the provider to take action to make improvements.

We observed that people knew the management team. One person said they were "Very happy with the majority of staff". The registered manager and operations manager spent time in the home and helped people when required.

Relatives gave us mixed views about how well led the service was. Comments included, "The manager rarely leaves the office" and "It is managed well, I am quite happy". We observed a number of relatives visiting the registered manager in the office to discuss a variety of things, they were open, friendly and responsive to relatives.

The facilitator for end of life care told us, "I have noticed all the refurbishments and more appropriate flooring that has been fitted in the past year. I think the staff seek advice and guidance appropriately for their residents. They listen to advice given and follow instructions from advice sought. I visit often unannounced and have had no cause for concern".

At this inspection improvements had been made to quality monitoring systems.

The registered manager and head of operations carried out a number of regular checks and audits. These included monthly medication audits, moving and handling equipment, daily manager's audits, and care plan audits. The registered manager also audited people's nursing records where community nurses had visited to provide nursing care, so they could keep a close eye on who was getting better and who was not. These showed that issues had been picked up; the registered manager explained how these had been addressed. We checked areas identified in previous audits to see if the relevant work had been done. Audits had been actioned quickly. The head of operations completed checks to ensure that audits had taken place and that they were robust. Actions from these checks had identified that improvements were required to cleaning processes and a concern with an odour. The registered manager and head of operations had met with cleaning staff to look at tasks and discussed changes that may improve the standard of cleaning in the home. The audit systems had not identified the issues with staff recruitment records and topical medicines records.

We recommend that registered persons review quality assurance tools to ensure the quality monitoring process is robust.

The policies and procedures had been reviewed 24 August 2016. This meant that staff had up to date guidance about how to deliver safe, effective, caring, responsive and well led care.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries,

Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager had notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, deaths and serious injuries and safeguarding events that had occurred.

Staff told us they felt free to raise any concerns but they were sometimes not listened to. They gave examples of requesting extra staff which supported key times of the day. We checked the staff meeting records and saw that this had been discussed. The registered manager had agreed to arrange for staff to start earlier in the morning to assist at busy times. The registered manager and head of operations both told us they were in the process of recruiting and arranging for this. Staff told us that they were aware of the home's whistleblowing policy and that they could contact other organisations such as the Care Quality Commission (CQC) and the local authority if they needed to blow the whistle about concerns. We had received information of concern from whistle blowers before our inspection.

Staff meeting records evidenced that the registered manager met with staff on a regular basis. The records showed that staff had discussed a range of subjects and felt confident to ask questions and make requests.

The staff were mostly confident about the support they get from the registered manager and senior staff. Staff told us, "I have confidence in [head of operations]"; "[Registered manager and head of operations] are very good for support" "We get good support, there are times when it could be better"; "We get good communication and information"; "To be honest I think it [support] could be better". This staff member went to tell us that the management team could help out in the mornings with the medicines rounds to make sure that the round runs to time. Other staff said, "They are quick to sort things out"; "We don't really see the management on nights, so I haven't built up a relationship with them. I feel managers should work a shift at night to see what we do" and "I do believe there should be a senior member of staff on at night". Records evidenced that issues raised by staff with the management team had been recorded; discussions had taken place to explore options to resolve some of the issues. The management team were in the progress of addressing the areas where staff had concerns. We spoke with staff and they told us that they had access to the on call staff member outside of office hours.

Staff had been sent a survey in April 2016 to enable them to feedback. Fourteen staff had responded. The surveys responses were mixed. There were a number of negative responses in relation to management of the service and decision making. The operations manager detailed that they had worked hard with the registered manager to address the issues raised. All the staff agreed with the statement, 'I understand the ethos of the home and believe the home is committed to delivering good and dignified care' which was asked in the survey.

Staff told us, "There is a good rapport between staff who work well as a team"; "I feel part of the team"; "We pull together as a team, we all get on it makes life easier"; "At the moment morale is good" and "We work well as a team, a nice bunch of girls". One staff member told us that communication was not good between staff on occasions.

The registered manager received support from the head of operations and through provider forums that took place in the local area. The registered manager and head of operations had developed a registered manager forum through Skills For Care for registered managers working in the local area. They were collating responses from registered managers and arranging for key speakers to attend future forums. The registered manager and staff demonstrated that they were passionate about providing good quality care to people. Staff told us, "I enjoy my job, my passion is to look after people"; "I do love the residents, I love care"; "I'm here for the residents, I like to care for the residents"; "I am determined to make changes" and "I love people, I am open eared. It is a Christian care home. I would most definitely recommend the home".

The head of operations met the provider regular to discuss the service, planned improvements to ensure the provider was kept up to date and informed about the service.

The provider states on their website; 'We aim to provide excellent care which respects each person as an individual. This is delivered in a friendly, respectful and dignified way; in a homely environment where service users feel happy and secure. We are committed to supporting residents of all faiths and those who have no faith but the home has a Christian ethos and works in partnership with local faith groups and churches to enable residents who are unable attend services, to continue practicing their faith, if they so wish. We place the rights of our residents at the centre of our philosophy and recognise each person as an individual. In this way we aim to be able to meet every need, be it physical, emotional or spiritual. We aim to support our residents who have dementia to live as full and active a life as possible. We observed that the providers' vision and values were embedded into practice.

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 provider and registered manager had failed to ensure care was delivered in a safe way. Regulation 12 (1)(2) (a)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not operated recruitment procedures effectively. Regulation 19 (1)(a)(b)(2)(a)(3)(a)