Friends of the Elderly

The Bernard Sunley Nursing and Dementia Care Home

Inspection report

College Road
Maybury
Woking
Surrey
GU22 8BT

Tel: 01483764300
Website: www.fote.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of The Bernard Sunley Nursing and Dementia Care Home took place on 22 December 2015 and 5 January 2016 and was unannounced.

The Bernard Sunley Nursing and Dementia Care Home is a care home which provides accommodation and nursing care for up to 60 older people, some of whom are living dementia. At the time of our inspection there were 54 people who lived there. The home is purpose built and set over two floors, with a passenger lift to all floors. The home is split into three units and had a variety of communal areas including lounges, dining rooms, quiet areas and a garden.

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

Although risk assessments were in place we noted inconsistencies in the recording of information on risk assessments which could put people at risk of harm. Arrangements in place to identify and support people, who were nutritionally at risk, were not up to date or monitored to minimise risk. This meant that people were placed at risk of harm as appropriate guidance and best practice was not always followed.

There were inconsistencies with how staff were effectively deployed to meet people's needs. The staff levels deployed had an impact on the care and support people received.

People had enough to eat and drink throughout the day and night.

People's care and support needs could be affected due to records not being fully completed or kept up to date. Although there were systems and arrangements in place, they were not robust or effective enough to monitor, reduce risks or escalate identified issues.

Staff had understanding of Deprivation of Liberty Safeguards (DoLS), the Mental Capacity Act (MCA) and their responsibilities in respect of this. Mental capacity assessments were not always fully completed and DoLS applications had been submitted in accordance with current legislation. We made a recommendation that the provider reviews their systems and ensures information is completed in line with the requirements of the Mental Capacity Act 2005.

People were cared for by caring staff. People's privacy was respected and promoted. We did see examples of caring practice from staff. People's preferences, likes and dislikes had always been taken into consideration and support was provided in accordance with people's wishes.

People were supported to have access to healthcare services and were involved in the regular monitoring of

their health. The home worked effectively with healthcare professionals and was proactive in referring people for treatment.

People told us they felt were safe at the home, one person told us, "I feel safe here and the girls look after me and I do not have to worry about anything." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place to minimise the risk to the home in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding.

Recruitment practices were safe and relevant checks had been completed before staff commenced work. Staff worked within good practice guidelines to ensure people's care, treatment and support promoted a good quality of life.

People received their medicines when they needed them and the administration and storage of them were managed safely. Any changes to people's medicines were prescribed by the person's GP.

People told us if they had any issues they would speak to the staff or the registered manager. People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

People had access to activities that were important and relevant to them. People were protected from social isolation with the activities, interests and hobbies they were involved with. Staff supported people with their interests and religious beliefs in their local community. Religious services were conducted weekly at the home. People's relatives and friends were able to visit.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home. People's care and welfare was monitored regularly to make sure their needs were met within a safe environment.

People told us the staff were friendly and management were always visible and approachable. Staff were encouraged to contribute to the improvement of the home. Staff told us they would report any concerns to their manager. Staff told us the manager of the home were very good and supportive.

We found one breach 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.

Peoples' risk assessments were inconsistent and did not always have accurate information about their risks.

The staff levels deployed had an impact on the care and support people received.

Recruitment practices were safe and relevant checks had been completed before staff commenced work

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

People received their medicines on time and they were administered and stored safely by trained and competent staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had enough to eat and drink throughout the day and night.

Staff had an understanding of current legislation. Mental capacity assessments were not always fully completed in accordance with current legislation. Deprivation of Liberty Safeguards applications had been completed and submitted.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The service worked effectively with healthcare professionals.

Is the service caring?

Good

The service was caring.

People said that staff were kind and treated with them with respect. Positive caring relationships had been developed between people and staff.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring.

People told us that staff treated them with respect and dignity when providing personal care.

People felt that staff knew them well and they were supported to make choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed when they entered the service and on a continuous basis. Information regarding people's treatment, care and support were not always up to date or person centred.

People had access to activities or interests that were important to them and were protected from social isolation through the range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Quality assurance checks were not always robust or effective to ensure that those risks were identified and monitored and safe practices were followed by staff.

Records were not always kept up to date or contain relevant information for staff.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

People who lived at the home told us the staff were friendly, supportive and management were always visible and approachable.

Staff were encouraged to contribute to the improvement of the home and could report any concerns to their manager who was very supportive.	

The Bernard Sunley Nursing and Dementia 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 22 December 2015 and 5 January 2016 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. Our expert by experience was a person who has personal experience of caring for someone who has dementia.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We spoke to 10 people living at the home, nine relatives, 14 staff including nurses, care workers, housekeeping staff, and registered manager. We also spoke to a healthcare professional visiting the home. We observed care and support in communal areas; looked at 8 bedrooms with the agreement of the relevant person. We looked at 12 care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, complaints records, policies and procedures and external and internal audits.

At the last inspection on 18 June 2013 there were no concerns found.

Requires Improvement

Is the service safe?

Our findings

Relatives told us they felt their family members were very safe at the home and with the staff who provided care and support. People told us, "Yes I feel safe enough. The girls will do anything for us." Another person told us, "I am safe because only the people who should get in get in." A relative told us, "No doubts. My [family member] is safe and secure here. They need a lot of care now and they get it."

People were at risk of harm as concerns were not always identified in accordance to their needs. Information reviewed was generic and not person centred and some information did not relate to the person's needs. For example where people had been diagnosed with depression, or who had behaviour that was challenging there was no specific risk assessment carried out to identify potential risks to themselves or others. We found that some people were at risk of malnutrition, although risks were identified, the actions to reduce these risks were not followed. For example where documentation had recorded that a person had changed from low to medium risk due to weight loss, information was not recorded in the care plan. Where a person had a weight loss of 5kg within two months no action had been taken to identify the cause. Food and fluid charts to record people's intake had not been completed daily either. This demonstrated that records were not completed or up to date and action had not been taken to minimise or keep people safe from risk of malnutrition or harm.

Although staff were knowledgeable about people's needs, and what techniques to use when people were at risk of harm, they were not able to tell us how many people were at risk of malnutrition or dehydration. The registered manager told us that everyone on the dementia unit should have a record of their fluid intake and output. This was not being done for anyone on the dementia unit. On our second visit we found that this had been rectified and they had been completed appropriately.

Where people were at risk of developing or for those with existing pressure sores there was a plan in place to reduce this risk which was followed by staff. For example by using pressure mattresses or pressure cushions. However mattress settings had not always been reviewed when people's weight had changed. This meant that the manufacturer's guidelines were not always followed to give comfort and alleviate pressure for those people who already have or are susceptible to pressure ulcers.

People were at risk of not having their dietary requirements met which could have an impact on their health. During our first visit we found that kitchen staff did not have up to date information about people's dietary requirements. There was inconsistency in the information provided, for example people who were diabetic or on warfarin there was no information about their dietary requirement or alternative options available. Warfarin is an anticoagulant used to prevent heart attacks, strokes, and blood clots and certain foods and drink have an impact on the effectiveness of the medicine. These concerns were brought to the attention of the registered manager who stated they would ensure that the information for each person was updated. On our second visit, information about people's dietary requirements were still not fully up to date. Although we noted that alternative food options had been provided.

Failure to assess and act upon risks to people was a breach of Regulation 12 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Where risk assessments were in place we noted that any healthcare issues that arose were discussed with the involvement of a relative, social or health care professionals such as GP or speech and language therapist. Risk assessments recorded risks identified in regard to people's care and support needs. Assessments and guidelines in place identified the level of concern, risks and how to manage the risks. Where people had mobility needs or were susceptible to falls or injuries, information was recorded to help minimise these.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place and staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding.

Staff had information on how to support people in the event of an evacuation. We observed information displayed regarding the Fire Evacuation plan. We saw in people's care plan a 'Personal Emergency Evacuation Plan' had been completed.

People told us they felt there was sufficient staff at the home. A person told us, "I didn't have to wait for care, I generally don't even need to ask for help, it's just there. I don't have to worry about anything." However, we found that there were not always enough staff effectively deployed to meet people's needs and this had an impact on the care provided. The registered manager informed us that the provider determined the staffing levels, which was not based on people's needs, although the registered manager stated they identified the number of staff they felt was necessary.

The service was divided into three units over two floors. On the ground floor there are two units, one was a residential unit where 7 people were being cared for and on the dementia unit there were 14 people being cared for. Care was provided by 1 senior carer on each unit and 3 care staff. On the first floor which was a nursing unit, there were 33 people being cared for by two nurses and eight care staff. The registered manager told us that sometimes additional staff were brought in to cover hospital appointments. We reviewed the staffing rotas over a two week period; we found that on five separate days staffing allocation for those days were below the minimum amount of staff required. We noted that the home used agency staff to cover absence, but some the agency staff had not turned up to work. This meant the home on these days was operating below the minimum staffing levels the registered manager had determined as being needed to support people safely.

We saw how the deployment of staff affected how people's needs were met. There were inconsistencies in the way people were supported. For example, we noted on various units a number of people were still receiving personal care at 11.30am. We checked care plans and there was no mention of people preferring to get up late. Staff told us, this was because there was "A lot to do in the mornings." During lunchtime we saw those that required support with eating had to wait a long time before staff could assist them. Whilst other people received the appropriate care and support. On the second day, there was a vast improvement with the care and support provided.
People were provided with the necessary equipment to assist with their care and support needs and to help keep them safe such as wheelchairs, walking frames and hoists. We noted that handrails were placed throughout the home to support people's independence.

People received their medicines safely and in a timely manner. A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph

of each person was on their MAR to ensure that staff were giving the medicine to the correct person. There was guidance for staff about the recording of medicines if a person refused to take their medicine. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded. Any changes to people's medicines were verified and prescribed by the person's GP.

People received their medicines from competent and trained staff. Only staff who had attended training in the safe management of medicines were authorised to administer medicines to people. Staff attended regular refresher training in this area and after completing this training, the registered manager observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken their medicines.

Medicines were stored safely. The storage and administration of all drugs were in accordance with National Institute for Health and Care Excellence (NICE) guidelines and the requirements of the Misuse of drugs (Safe Custody) Regulations 1973. There were written individual PRN [medicines to be taken as required] protocols for each medicine that people took. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. The procedures in place meant people should receive their medicines in a consistent way.

Staff knew what to look for and what to do if they suspected any abuse. The home had a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults at risk. This provided staff with up to date guidance about what to do in the event of suspected or actual abuse. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme. A member of staff told us, "I would not hesitate to report any concerns to my manager."

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. There was a staff recruitment and selection policy in place. All applicants completed an application form which recorded their employment and training history. The provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. Staff were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or are barred from working with vulnerable people. However we found with the files that we review two files only had one reference and one file had no evidence of a DBS check. After the inspection, the registered manager confirmed they had obtained the information.

Requires Improvement

Is the service effective?

Our findings

People living at the home and relatives spoke of the staff working at the home. A person told us, "The new staff are very good, young, friendly, know what they are doing. I trust them." A relative told us, "They are very thorough. My [family member] had a fall and phoned me to say that they had seen the doctor. They have a very good relationship with the local surgery."

Staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA, and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People should be enabled to make decisions themselves and where this was not possible any decisions made on their behalf should be made in their best interests. We reviewed the provider's records and saw that staff had received training in the MCA and DoLS. Staff told us, "They found the training useful in knowing when and how to discuss everyday decisions with people like what to wear and choosing meals, e.g. showing people what was available."
People's right were not always upheld in light with current guidelines. The registered manager told us that there were some people who lacked mental capacity. Mental capacity was not routinely assessed or considered and action taken when a person was found to lack capacity. We found inconsistencies in the information recorded on people's files where people lacked capacity to consent, there were not always evidence of best interest meeting taken place or who had legal responsibilities to make decisions on their behalf. For example where people had covert medicine no capacity assessment or best interest meeting had been carried to ascertain whether it was in the person's best interest.

We recommend that the provider reviews their systems and ensures information is completed in line with the requirements of the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Most people were able to move freely around the house; however some of the units could only be accessed by coded key pads. We noted that some people movements were restricted by the keypads and those who required bed rails. Bed rails are used to keep people safe whilst in bed. The registered manager had completed and submitted DoLS applications to the local authority for people living at the home despite possible restrictions in place. A person told us, "I am never stopped from doing anything."

Despite formal consent processes not being followed in full, staff checked with people that they were happy with support being provided on a regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions. A member of staff told us, "I make sure I show people things to help them make decisions like dresses, food and the shower sign."

All of the people told us that they usually enjoyed the food at the home. One person told us, "Food is very good-highlight of my day." Another person told us, "We had a wonderful barbeque here. X had all his food pureed can't fault it." The chef prepared and cooked all of the meals in the home. People were involved in the consultation about the choice of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; an alternative option was available if people did not like what was on offer. Staff confirmed that a dietician or speech and language therapy team were involved with people who had special dietary requirements. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required.

Lunchtime experience was different on the two days we visited. The first day, there were inconsistencies in the experience people had. For example some experienced lunchtime as a social occasion, where others did not as staff did not interact with them. However on the second visit, lunchtime was a different experience, it was consistent, people were given support to eat, the atmosphere was relaxed and people were seen to be enjoying themselves. There was music playing in the background and some people were seen singing and laughing with other residents and staff. People were able to choice what they wanted to eat as staff offered them a choice of two dishes. Staff offered finger food to a person that did not what to eat what was on offer. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, communal lounges or in their room. People were supported to have their nutrition and hydration needs met. Staff were aware of and there was information about people's food likes and dislikes and preferences such as religious or cultural needs was available.

There was qualified, skilled and experienced staff to meet people's needs. The provider promoted good practice by developing the knowledge and skills of new staff required by the Care Certificate to meet people's needs. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The registered manager confirmed that they would use agency staff and would require the same agency staff to attend to ensure consistency and reduce the disruption to the home.

The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities through regular training and supervision. Staff confirmed they received training that was relevant to their role. A member of staff told us, "I have undertaken lots of training I did moving and handling and this is taken every year." Training covered areas such as: medicines, safeguarding, moving and handling, allergens awareness, food hygiene, dementia awareness, Mental Capacity Act (MCA) 2005, and Deprivation of Liberty Safeguards (DoLS).

Staff told us that the training they received was "Suitable to provide the skills to do my job" The registered manager told us each staff member had attended a two day dementia awareness course which included an experiential day where staff were able to simulate different things including visual impairment, hearing impairment, being hoisted, eating pureed food and being supported to eat. This enabled staff to have experience of what it was like for people living with impairments.

Staff told us they had regular meetings with their line manager to discuss their work, training and performance. A member of staff told us, "I have bi-monthly supervision with a nurse and find this really useful. I feel I can discuss anything." They went onto say, "I requested moving and handling refresher training which was acted upon and provided." Another member of staff told us, "All my supervisions are observational and the nurses feedback on what I have done well and areas which could be improved. I find this useful guidance."

People had access to healthcare professionals such as GP, district nurse, optician, dietician, physiotherapist, speech and language therapist and social care professionals. A healthcare professional visiting the home told us, "I think they are pretty good at nursing." They went on to say, "I felt that the service was managed well." "By and large they all seem very kind, I would have my family here, I would recommend it, very good dementia care." We saw from care records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records. Staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

The home was adapted to meet people's needs. We saw that some people had memory boxes that contained photographs or items of importance near the door to their room so it was easily recognisable to find their room. People's bedrooms were personalised with pictures, photographs or items of personal interest. People's art work was displayed throughout the home integrating it into the home outside of their rooms. All communal areas had large signs on them to describe the room. Areas of the home were painted in different colours which helps those living with dementia to move around the home. It was easier for people living with dementia or who had impaired sight to find their rooms or their way around the home.

Good

Is the service caring?

Our findings

One person told us, "Staff are very friendly and go out of their way to do thing for me." Another person told us, "I get very good care, can't fault it." A third person told us, "I have some very kind people looking after me." A relative told us, "110% happy with the care here."

People are able to make choices about their care and support, such as when to get up in the morning, what to eat, what to wear and activities they would like to participate in and help maintain some independence. People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them. We noted that people had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations.

People's needs in respect of their cultural needs are understood by the staff and met in a caring way. Staff told us there was a person who had dementia and had reverted back to their native language. As some staff spoke this language, the person has asked staff to speak in this language which 'makes them feel at home and happy.' This demonstrated that people are support by staff who can meet their cultural needs.

Staff knew about the people they supported. A relative told us, "Mum is far more at ease she was always worried but now, since being here, she is not as anxious." Another relative told us, "They are caring attentive people." We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. We observed where a person was distressed as they had lost something. The staff member reassured them that someone had gone to look for it. As the person was distressed and said they needed it now. The staff member replied, "Ok, shall we go and look for it together then?" The person seemed reassured and went with the staff member. Information was recorded in people's care plans about the way they would like to be spoken to and how they would react to questions or situations.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. Staff were observed knocking on people's bedrooms doors before entering. When they assisted people to move from one part of the home to another staff were heard offering encouragement and words of reassurance to people. Comments included, "That's good" and "You're doing fine." People were seen to smile in response.

People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Staff told us, "I always tell people what I'm doing and what help I'm giving to reassure them. I think it's important to start the day off in an upbeat mood for people." We observed staff transferring people from a wheelchair to a chair; staff ensured that clothes were placed in a safe and dignified way throughout the transfer.

People were involved in making decisions about their care. A relative told us, "Just had our 6 monthly

review. It was very thorough assessment prior to coming in, initially for respite."
We observed that when staff asked people questions, they were given time to respond. Staff did not rush people for a response, nor did they make the choice for the person. Relatives and health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were supported to express their views about their care, support, treatment or the home in different ways such as: day to day conversations, meetings and social activities.

Relatives and friends were encouraged to visit and maintain relationships with people. People were able to attend various activities taking place inside the home and outside in the local community, for example sing alongs, visiting choirs or exercise sessions. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres and people from the religious community visited the home.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information about people were kept in a secured office. This ensured that people such as visitors and other people who were involved in people's care could not gain access to their private information.

Requires Improvement

Is the service responsive?

Our findings

Staff were inconsistent in the way they responded to people's needs. A relative told us, "Some staff lack compassion. I have asked if my [family member] could have a designated carer but that hasn't happened and they have different people and finds it difficult." Another relative told us, "I think that the staff are exceptionally friendly and patient towards residents."

We observed examples of inconsistencies in the way staff responded to people's needs. One person required a urine dip test to ascertain whether they had an infection. It took staff three days to carry the test. There were no records of any attempts made and senior carers had not communicated that it had been done. This person could have been at risk of infection and necessary medical treatment could have been delayed due to the test not being carried out promptly. Where another person informed staff they were in pain and staff told them they would examine them after lunch and in the meantime staff offered them pain relief. This demonstrated that staff were inconsistent in how they responded to people's needs.

Care records held information which identified individual's care and support. Any changes to people's care should be updated however the information recorded was not always up to date. Where people had specific health care needs such as living with mental health issues these had not been taken into account when planning the care or identifying what support they needed. For example where a person had anxiety, there was no information reflecting this. There was no mental health or behavioural support guidelines in place to guide staff in supporting them. Behavioural monitoring chart recorded 12 incidents between 7 and 31 December, ten incidents involved assaults/attempted assaults to staff. Another person who had a visual impairment, guidelines were provided to staff to ensure they provided the appropriate support such as prompts to staff to ensure room is tidy and things left in the right place. This demonstrated that there were inconsistencies in the information provided to support people in accordance to their needs.

People received care that was based on their individual needs. Although some current information was not recorded, staff were knowledgeable about people's needs. Assessments were carried out before people moved into the home and then reviewed once the person had settled in. Details of health and social care professionals involved in supporting the person such as their doctor and or care manager were recorded. Other information about people's medical history, medicines, allergies, physical health, identified needs and any potential risks were also recorded. This information was reviewed before a care plan was developed and care and support given. This enabled staff to build a picture of the person's support needs based on the information provided.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff. Daily records were also completed to record support provided to each person; however they were very task orientated. There was no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues. This showed us that although there was up to date information about the support provided, the information was not person- centred which would enable staff to monitor any issues that might arose.

Staff responded positively to a person who appeared to be distressed. The person was anxious about a family member and whether they were coming to visit them, to ease the person distress, staff contacted them and was able to reassure them. Staff member told us, "We know our residents very well. One lady loves rabbits so if she is worried I walk with her to see the home's pet rabbit. That seems to settle her."

People confirmed that they took part in the activities in the home. People told us, "I love dancing and staff know that and we have a dance sometimes." Another person told us, "I like to join in with things it makes the days better." There was a large board with pictorial signs of what the activities were. This mornings was listed as 'light exercise, unfortunately this did not take place as the member of staff had called in sick. Activities included sing alongs, arts and crafts, movies, board games and 'Pets for therapy'. Items were placed throughout the home which created sensations that could assist relaxation, or stimulate people's senses. For example, objects for people to handle such as hats, costumes, books, magazines and dementia dolls.

People were provided with the necessary equipment, care and support to assist with their care and support needs. For example, different types of wheelchairs for use inside and outside of the home, and specialist beds adapted to people's needs. Information regarding people's individual needs and treatment was recorded in their care records; and staff were knowledgeable about their needs.

People and relatives confirmed that they were aware of the complaints system. There was mixed feelings about the way complaints were handled. One person told us of a concern they had about the restructuring of the home, their family member had to move out of the room they had for years. Concerns were expressed to the manager but they told us the response they received was not satisfactory to them. Others felt their comments and complaints were listened to and acted upon appropriately. People were able to identify a complaint by completing a form, discuss the issue with staff, the manager or at the relatives or residents meetings. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms.

We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the service user guide which people kept in their rooms. The home maintained a complaints log and these were dealt with in a timely manner, in accordance to their complaint policy. There were six complaints made in the last twelve months. We noted that responses to the complaints contained action to be taken and offers of apology where appropriate. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, and Local Government Ombudsman. We also saw lots of compliments received by the home.

Staff told us they were aware of the complaints policy and procedure as well as the whistle- blowing policy. Staff knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously.

Requires Improvement

Is the service well-led?

Our findings

People told us the home was "Thought that this place was brilliant from the first time I came in and I have not been disappointed." And "I am lucky to have found this place."

Care records did not reflect up to date information regarding people's care or support needs which meant new or agency staff who did not know people might not be working to the most up to date information. The records were completed in an inconsistent way. People's care and support needs could be affected due to records not being fully completed or kept up to date. Risk assessments were not always person centred or relevant to the person's health needs. Where risks were identified, information and checks were not always carried out, updated or monitored to minimise risk. Their care plans lacked information on how to identify and manage these situations.

There were a number of systems in place to make sure staff assessed and monitored the quality of care provided to people living at the home. We reviewed various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. We noted that fire, electrical and safety equipment was inspected on a regular basis. However audit that reviewed care plans were not robust or effective enough to monitor, reduce risks or escalate identified issues. For example the audits did not identify the missing information on people's care plans or action need to be taken. Such as ensuring that daily fluid and intake charts were completed and up to date, where risks had been identified, action was taken. The lack of up to date information had an impact on the care and support provided. The registered manager told us they would review the arrangements in place and ensure the information is up dated.

We saw records of accidents and incidents that occurred every month. We reviewed an analysis of the falls were carried out. The analysis identified a number of issues and as a result recommendations and learning outcomes were made. There were maintenance records which identified repairs and maintenance checks to be carried out. There were monthly audits which covered areas in environment, nurse call systems, health and safety, communication needs and care plans. We noted that action taken was recorded.

People and relatives were involved in how the home was run in a number of ways such as daily conversations with staff, feedback forms and meetings. We reviewed documentation of a relative's meeting held in November 2015 where issues in regards to food, budget, and equipment were discussed. There was a record of actions taken.

Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. Another member of staff told us, "We are very lucky to have a manager who cares." Staff told us they had good management and leadership from the management team. Staff were able to contribute through a variety of methods such as staff meetings, one to one meetings and group supervisions. Staff told us that they were able to discuss the home and quality of care provided, best practices and people's care needs.

People, relatives and staff said that the manager and staff were approachable and open to suggestions. One

person told us, "The manager was approachable and was seen around the home." Whilst another person told us, "There is a good atmosphere in the home." Residents and relatives spoke highly of the manager and told us that they were concerned that she was due to leave, how this would impact on the home. People were supported by a consistent staff team. Staff told us, "The manager communicates with staff very well and senior managers visit all the time. We're kept up to date with what's going on." Staff said that they worked well as a team. Another member of staff told us, "It's a good place to work, that's why I stay here. There's good teamwork and good management, people get a good service."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the home. Events had been informed to the CQC in a timely way.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure safe care to people in the home. Regulation 12 (1) (2) (a) (b)