Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Copper Hill Residential and Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Good

Overall summary

This was an unannounced inspection carried out on the 19 and 27 November 2014.

Copper Hill is a large care home with nursing and is registered to provide accommodation for up to 180 people. It provides residential services, nursing care services, dementia care services and mental health services across six separate units. At the time of our inspection there were 98 people living at the home.

At the last inspection in May 2014 we found the provider had breached five regulations associated with the Health and Social Care Act 2008.

We found that the service did not demonstrate how people who used the service had consented to decisions affecting their care and where people did not have the capacity to consent; the provider did not act in accordance with legal requirements required of them.

Summary of findings

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare and people did not always receive care that met their assessed needs. People who used the service were not protected from the risk of abuse as the provider did not always have suitable arrangements in place to fully protect people's welfare. We saw there was not always enough qualified, skilled and experienced staff to meet people's needs and systems in place to identify, monitor and assess risks to the health, safety and welfare of people using the service were not effective.

We told the provider they needed to take action and we received a report on the 4 June 2014 setting out the action they would take to meet the regulations. We also asked the provider to submit a monthly update on these actions and they had done this. The provider told us they would have met the regulations by the end of August 2014. The provider also voluntarily agreed to suspend admissions to the home until such a time as we would be satisfied that improvements had been made regarding the identified breaches in regulation.

At this inspection we found improvements had been made with regard to these breaches. However, we found other areas of concern.

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 and associated Regulations about how the service is run.

We found medication practice not did not always protect people against the risks associated with the unsafe use and management of medication.

We found gaps in care records with regard to risk management which could lead to people's needs being missed or overlooked.

People who used the service said they felt safe at the home and were well looked after by suitably trained staff. They said there were sufficient staff to meet their needs. Some relatives commented staffing levels were much improved recently. People told us they enjoyed the activities on offer in the home and they had plenty to do.

People were not deprived of their liberty unlawfully. The registered manager and provider were aware of their responsibilities regarding the Deprivation of Liberty Safeguards and had ensured the appropriate assessments were completed.

People's health needs were met well and records showed that appropriate, timely referrals were made to health professionals when needed. We saw care practices were good. Staff respected people's choices and treated them with dignity and respect.

People told us they enjoyed the food in the home and there was a good variety of choices available. We saw people were given good support when they needed assistance with their meals. However, on one unit we saw staff's practice regarding explanations of food served needed to be improved.

Staff spoke highly of the training and support they received to enable them to carry out their job well. They said they had regular opportunity to discuss their role and their training needs. We noted that annual appraisals had not been carried out for all staff but there were plans in place to ensure this.

People told us they were confident to make a complaint if they needed to. Staff were aware of how to support people to raise concerns and complaints and we saw the provider learnt from complaints and suggestions and made improvements to the service. There were effective systems in place to manage, monitor and improve the quality of the service provided.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Medication practice was not safe and improvements were needed. There was a risk that people would not receive their prescribed medications as directed.

Individual risks had been assessed and identified as part of the care planning process. However, the documentation showing how risks were managed were not easily accessible to all staff.

People who used the service said they felt safe and knew how to report concerns about their safety. We saw robust safeguarding procedures were in place and staff understood how to safeguard people they supported.

There were enough staff to meet the needs of people who used the service. Recruitment practices were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not all show they were respectful of people's rights to refuse care and support or at times offer explanations when delivering care and support.

Mental capacity assessments had been carried out for people who used the service. Some of these did not show who had been involved in the assessment as was required by the Mental Capacity Act 2005.

Steps had been taken to review the needs of people who used the service to make sure no-one had their liberty restricted unlawfully.

Health, care and support needs were assessed and met by regular contact with health professionals.

Staff said they received good training and regular supervision which helped them carry out their role properly. The registered manager confirmed they were going to make improvements to the training on offer and this would include more first aid, diabetes and end of life care in the future.

Is the service caring?

Good

The service was caring.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity.

People who used the service and their relatives spoke highly of the care they received. People told us that staff treated them well and responded to their care and support needs well.

Summary of findings

Is the service responsive?

Good

The service was responsive.

There were systems in place to ensure pre-admission assessment were carried out to identify needs of people who used the service before they moved in to the home. Care plans were detailed and person centred. They gave a good account of people's support needs

People were provided with a good range of activity. They told us they had enough to do and enjoyed what was on offer to them.

There were good systems in place to ensure complaints and concerns were fully investigated.

Is the service well-led?

Good

The service was well-led.

There were systems in place to assess the quality of the service provided in the home. These were effective in identifying risks and ensuring continuous improvement in the service.

People spoke positively about the approach of staff and the management team. Staff were aware of their roles and responsibilities and knew what was expected of them.

People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning or

improvement.

Copper Hill Residential and Nursing 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 checked 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 27 November 2014 and was unannounced.

At the time of our inspection there were 98 people living at the home. During our visit we spoke with nine people living at the home, six relatives, twenty one members of staff, two visiting health professionals, the registered manager, the regional manager and the quality manager.

We spent some time observing care in the communal areas to help us understand the experience of people living at the home. We looked at all areas of the home including people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to people's care and the management of the home. We looked at 17 people's care records and ten people's medication records. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

On the first day, the inspection team consisted of seven inspectors, a specialist advisor in mental health, a specialist advisor in governance and two experts by experience in people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the inspection team consisted of three inspectors.

Before our inspection, we reviewed all the information we held about the home. The provider had completed a provider information return. This is a document that provides relevant and up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission. We were aware of concerns that the local authority and safeguarding teams had and their on-going investigations at the home. Healthwatch feedback stated they had no comments or concerns regarding the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

We looked at medication records for ten people who used the service and found some concerns about medicines or the records relating to medicines for six of those people. One person had been prescribed controlled drugs. These were accounted for in the controlled drugs register but there was no medication administration record (MAR) sheet with instructions for the use of this medication. There was a risk this medication would not be given as prescribed when needed. Staff were inconsistent in their response as to why these medications were needed. It was not clear if the medication was prescribed for pain relief or 'agitation'. There was no care plan in place to describe the circumstances when the medication would be given. Some people were prescribed pain relief patches. Records for two people showed these were not being placed on the skin at different sites with the required interval of time in between as described by the manufacturer's instructions. This could lead to skin damage.

Two people had covert medication administration plans in place. One person's records did not have the documentation showing how this had been agreed it had been archived with old records meaning staff did not have immediate access to it. Staff gave differing accounts of how they administered this medication. One staff member said they put the medication in a drink, another said they administered it from a spoon with a little liquid. This person's care plan said they took their medication better if taken in drinks as they had a tendency to spit it out. Another person's covert medication administration care plan stated that all medications were to be in liquid format; however, we saw paracetomol had been prescribed in tablets. It was also unclear from the care plan instructions if medication was to be administered in food and drink or with food and drink.

There were systems in place to check the stocks of medication. However, we saw there was a discrepancy in two people's stocks of medication. A salbutamol inhaler could not be accounted for. Another person had an antibiotic missing and staff could not explain how this had occurred.

One person had been prescribed lactulose; to be given as and when necessary (PRN). There was no MAR sheet for this medication and therefore no instructions for staff on its use. Another person had been prescribed a PRN medication with instructions on the MAR chart as 'take one daily, increase to two if not improving'. There were no care plans or guidelines for staff to follow regarding what signs of improvement were and when one or two sachets of this medication would be needed.

We looked at medication storage and saw that on one of the units the medication fridge temperatures were not recorded to ensure they were within safe limits. We also saw eye ointment stored in this fridge that should have been stored at room temperature according to the manufacturer's instructions.

We found that appropriate arrangements were not fully in place in relation to the recording and administration of medicines. This is a breach of Regulation 13 (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked at people's care records we saw that for some people risks had been identified through the assessment and care planning process. Most of these risks were supported by risk management plans and were managed positively. They were individualised and evidence based. For example, risks associated with the use of bedrails, nutrition, refusal to sleep in a bed, moving and handling, mobility and skin integrity, the use of a lap belt in a wheelchair and the use of a safe soft hand hold.

However, risks identified through care planning were not always supported by robust, individualised risk management plans. One person had risks associated with behaviour that challenged others and it was recommended a safe soft hand hold technique was used to prevent self-injury or injury to others. However, the risk management plan did not have the details of how this was carried out and the timescales involved. We saw risks such as self-harm had been identified in one person's care plan and a support plan put in place. However, the risk management plan had not been completed. These gaps in records could lead to people's needs being missed or overlooked. Staff we spoke with could describe risks for people who used the service and what they did to minimise the effects of them. Staff confirmed it was sometimes hard to find the appropriate documentation in people's records as the files were so bulky. They did though; confirm that risks were highlighted well to them through induction, shadowing, handovers and having time to read care documentation.

Requires Improvement

Is the service safe?

We found that steps had not always been taken to ensure people were protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each person who used the service in relation to their care. This is a breach of Regulation 20 (Records) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Ligature risks in the mental health unit in the home had been reviewed and work was underway to refurbish the rooms in this unit to ensure they were furnished with anti-ligature point fittings and fixtures. The needs of people who used the service had been carefully considered in the planning of this work to reduce as much anxiety and disruption as possible.

People who used the service said they felt safe at the home. One person said, "I do feel safe here. I am well looked after." Another person said they felt their belongings were safe and no-one at the home had ever upset them. Relatives had no concerns about people's safety. One relative said, "We know (our relative) is fine here, we don't worry about her. She likes it here."

Staff were aware of and familiar with safeguarding procedures. They had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents or poor practice. They were aware of external agencies they could contact. They also told us they were aware of the whistle blowing policy and felt confident to raise any concerns with the registered manager knowing that they would be taken seriously. Staff told us they had received training on safeguarding adults and this gave them the information they needed on how to recognise harm or abuse and what to do if they felt anyone was at risk. Training records confirmed staff had all completed training as described. The home had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff.

Staff spoke of the training they had received in managing actual and potential aggression. They said this had been useful and effective training when working with people whose behaviour challenged others. They could describe the techniques of safe soft hand holds used and were aware of the need to record any incident where a safe soft hand hold was used. They were also aware that two staff were needed to ensure people's safety. Staff were familiar with de-escalation techniques as a way of managing behaviour that challenged others and confirmed they were trained to do so. They also spoke of systems in place to monitor people's negative behaviours which included trying to identify 'triggers' so they could prevent incidents. However, one person's records we looked at did not have an up to date behaviour monitoring chart in place for staff to be able to monitor any trends. We were told this was in the person's daily notes which meant it was not easily accessible. On other units in the home we saw there was good use of behaviour monitoring charts.

People who used the service and visitors had no concerns about staffing levels, and we observed staff being able to combine tasks with interaction with people quite easily. We did not observe anyone seeking assistance having to wait for a response. One relative said they had previously had concerns about staffing levels but said that since new staff had been recruited it was much improved and they had no concerns now whatsoever. They said they thought the staff were knowledgeable and able to manage incidences when their family member exhibited behaviour that challenged others.

Most staff across all the units in the service said they had sufficient staff to meet people's needs. On one unit, one staff member said, it could be challenging when less experienced staff were on duty. On another unit a staff member said the staffing levels were 'stretched' at peak times such as lunch time. Our observations showed staff were busy at this time but they met people's needs well.

On both days of our visit, people's needs were met well and staff took the time to sit and interact with people who used the service. Although, on one unit we visited we saw staff tended to congregate at times in one side of the unit, leaving less staff to supervise people. We mentioned this to the registered manager who agreed this should not be happening and agreed to address it with the staff team. They also told us that future plans for this unit included both sides of the unit having a separate staff team.

Appropriate recruitment checks were undertaken before staff began work. These checks helped to make sure job applicants were suitable to work with vulnerable people. We looked at the recruitment process for six members of staff. We saw there was all the relevant information to confirm these recruitment processes were properly managed.

Requires Improvement

Is the service safe?

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. We saw evidence that additional care plans had been developed and implemented following accidents or incidents and evaluated as needed to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

People told us they received good effective care and staff were aware of their needs and understood what was important to them. One person told us, "I like being left to myself and they know that." At lunch time we saw arrangements were made for this person to dine at a table on their own. We observed staff having meaningful and engaging conversations with people who used the service that showed they knew the person's history and likes and dislikes. One person said, "I am more able to come and go than the others; they know I like to do my own thing and they let me. It's not that they ignore me, but they know when I'm ok and can leave me to get on with things."

People were positive in responses about the staff's ability to provide quality care. Phrases such as "Very good" and "They know what they are doing" were commonly used in response to questions. Staff we spoke with knew the needs of people who used the service well. They could describe people's individual support and routines. We saw on most occasions people were asked for their consent before any care interventions and staff could describe what they would do should people refuse care. They described gentle encouragement techniques and showed they were aware of people's rights to refuse care. One staff member said, "You can't make people do something they don't want to do." However, one staff member said they would "just do it" if a person continued to refuse care despite all best efforts to persuade them. This was not respectful of people's rights. We looked at the provider's policy on consent and rights saw these had not been reviewed on the date planned. The registered manager and quality manager said a number of policies were currently on hold as the provider was reviewing the whole system of policies.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager informed us they had identified a number of people who used the service as potentially being deprived of their liberty. The service was aware of the changes in DoLS practice and were in contact with the local authority to ensure the appropriate assessments were undertaken to make sure people were not unlawfully restricted.

We asked staff about the Mental Capacity Act 2005 (MCA). They were, in the main, able to give us an overview of its meaning and could talk about how they assisted people to make choices and decisions to enhance their capacity. The registered manager said they had undertaken a lot of new training in this area and were now checking staff's understanding and competency of the MCA when senior managers carried out monitoring visits in the home. We looked at MCA assessments and could see there were improvements and a new assessment tool had been introduced. The majority we looked at were robust and demonstrated the principles of the MCA had been applied. This included assessment of capacity to consent to care provision according to care plans and the use of the least restrictive measures when carrying out care in people's best interests. However, some assessments did not show who had been involved in the assessment and how decisions about people's capacity had been made. This information needed to be recorded better to fully ensure the principles and legal requirements of the MCA.

Records showed arrangements were in place that made sure people's health needs were met. Staff had regular contact with visiting health professionals such as GPs, speech and language therapists, dieticians and tissue viability nurses. We saw systems had been put in place to ensure a timely response to medical emergencies. This included a nurse on-call rota and the use of the providers 'early warning' tool to identify anyone with deteriorating health. People who used the service spoke highly of the medical support they received. Comments included; "I get my feet and my nails done" and "The staff do it. They get a doctor when I want one."

People spoke positively of the food and menus in the home. One person said they sometimes found things a bit bland but told us they kept their own store of condiments to prevent this. We observed the lunchtime meal and saw staff provided people with appropriate assistance and no one was rushed to eat their meal. Staff sat with people to encourage them to eat and make the dining experience a pleasant, sociable experience.

However, on one unit, staff did not offer explanations before putting clothes protectors on for people, this was not respectful of people's choice to wear one or not. Also we noted staff did not always tell people what the food being served was. We were told that food choices were made the day before and were concerned people may have forgotten what they had ordered without staff explaining to them. We also saw that some people on one unit finished their breakfast late and were then served their lunch. We

Is the service effective?

saw there was a gap of less than two hours between the meals and therefore a risk that people would not eat their lunch and be hungry before their evening meal was served. On another unit we saw a person tipped their food on to the table and was not given immediate assistance. The staff member sat at the table waited for another staff member to come and give assistance. They could not explain why they did this.

Food looked well-presented and appetising. We saw portion sizes were good and there was plenty of variety and choice for people. A relative told us the food always looked nice and spoke of their involvement in planning the diet for their family member. We saw people were provided with regular drinks and snacks throughout the day, this included afternoon tea where gluten free cakes and cakes for people with diabetes were provided.

We found people's nutritional needs were assessed to see if they were at risk of malnutrition and where risks were identified action was taken. For example, a referral to a dietician regarding weight loss. We looked at the records of two people who had diabetes. We saw their nutritional needs had been assessed, however, the records did not show evidence of a healthy eating care plan and how this was encouraged. We discussed this with the registered manager who said the catering staff were trained in the provision of diets for people with diabetes and 16 staff across the service had completed a local authority training course on meeting nutritional needs. They said other staff had completed training by the provider in nutrition and hydration and the records confirmed this.

We saw there was a system in place to ensure staff's mandatory training was kept up to date. Courses included; health and safety, behaviour that challenges, food safety, safe moving and handling and infection prevention and control. Records showed a high percentage of staff had completed their mandatory training and induction training. Some specialist training had been provided for staff. This included; dementia awareness, pressure ulcers, a three day course on working with people with enduring mental health needs and managing behaviour that challenges. Records showed a programme of training on catheterisation was currently underway.

However, we noted there was no training available on diabetes, even though a number of people who used the service had a diagnosis of this. The registered manager agreed this was something they needed to consider for the future. We also saw that only two staff were trained in end of life care, despite this being something offered by the service. Again, the registered manager had identified this gap in training provision and we were told the provider is introducing this training from January 2015.

We saw first aid training had recently been introduced and a small number of staff had completed this training. We discussed the policy on first aid training with the registered manager as we noted the policy said a first aid needs risk assessment should be carried out to determine the training needs within the service. The registered manager said this had not been done. It was therefore unclear if there were enough staff trained in first aid to meet the needs of the service. The registered manager said their on-going training programme would ensure this for the future.

Staff told us they received good levels of training appropriate to their needs. Comments included: "Training is very good" and "Training is good, have done all sorts." Staff said their induction training had prepared them well for their role. They said they were well supported in their role and received regular one to one supervision meetings where they could discuss their performance and any training and development needs. One staff member said, "I have had supervision, I like to discuss my ideas with the manager." Another said, "We discuss how things are going, how we are, do we need any more training." Some staff said they had received an annual appraisal of their role and needs. However, the registered manager said they had not carried out appraisals for some time and this was a planned area of improvement. They said new documentation for appraisal was to be introduced in January 2015.

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with all told us that they felt that the staff were caring and supported them or their family member very well. People said staff took the time to sit and talk with them in a meaningful way. One person said, "They sit and have a chat with me all the time, we get on very well." Another person said, "I talk to them a lot." People told us they were supported to maintain their independence. One person said, "I want to keep my mind resilient and they respect that. They know I won't get lost so they let me go to the post office or the shop, and they aren't always fussing me. They don't ignore me but they don't smother me either." One person spoke highly of the personal care they received.

People's relatives told us they were very satisfied with the care their family member received. Comments included: "Care is fine" and "Can't fault the care." One relative said they felt staff were 'on top' of their family members care needs.

We saw people who used the service had positive and caring relationships with staff. Staff were seen chatting on a one to one basis with people, offering reassurance if people were upset or distressed and responding to people with understanding and compassion. People were asked what they wanted to do and staff listened. People appeared comfortable in the presence of staff. People looked well-presented and well cared for. They had clean clothes and their hair styled and brushed.

We saw staff assisted people when required and care interventions were discreet when they needed to be. Staff accompanied people to their bedrooms or toilets if support was needed. A visitor told us, "They are always discreet and careful, there's no big fuss made about things like that." Staff showed consideration to each person on an individual basis; they offered people choice and gave people time to make decisions such as what activity to be involved in or what meal to have. Staff made sure people were involved in aspects of the day and their care, for example, inviting people to participate in activities or discussions.

Staff had been trained in how to respect people's privacy, dignity and confidentiality and showed they understood how to put this into practice. The registered manager told us this was covered during induction and regularly discussed in staff meetings and one to one supervision meetings. We were told of the policies and procedures in place which supported this training. They included philosophy of care and rights and consent. A staff member spoke of their training in privacy and dignity. They said, "It's a priority we all treat people with dignity, this is reinforced in training, induction, meetings and supervision." Another said, "We like to do our very best for people."

On some units staff had been appointed as Dignity Champions. These were staff who had received training to enable them to carry out this role and would be expected to demonstrate and promote good practice and challenge any bad practice with regards to respecting people's dignity at all times. There were pictures on display identifying which staff had taken on these roles.

People who used the service were not always able to tell us about their involvement in decisions about their on-going care. We did however, observe staff regularly asking people if they needed anything and offering choices such as where they were located, whether they wanted to go back to their rooms and what they wanted to do. Relatives told us that they had been involved in care planning. One person's relative told us they had recently spent time with the staff going through, updating and reviewing their family member's care plan. Others told us that staff kept them informed of any changes or outcomes of appointments their family member attended. One relative said, "They talked to me at length and keep me updated all the time."

The registered manager stated that early next year she was going to send a letter to relatives inviting them to a meeting to seek their input into people's care plans and that staff time to undertake this would be made available. This will mean that people's relatives will be more involved in decisions related to their family member's care. They said they had recognised they needed to formalise people's involvement to demonstrate further how they encourage this.

We saw evidence in care plans that end of life care had been discussed sensitively with people who used the service and their relatives. This also included discussions with a local hospice. A staff member told us people were never left alone when at the end of their life. A relative told us they had received good support from staff when discussing care needs and had been offered the opportunity to meet with a palliative care nurse.

Good

Is the service caring?

It was clear from our discussions with staff that they had a good understanding of the needs of people who used the service. They were aware of their individual needs, choices and preferences. They described good care practice and showed this through the support we observed. They maintained people's dignity and were respectful, friendly and welcoming towards people. One staff member said, "Consistency in care is a priority, staff get to know people and what their likes and dislikes are." Another said, "It's important that we know and remember who they were before they were here."

People who used the service and visitors felt that visits were not restricted and visitors told us that they felt welcome when they arrived. We observed staff chatting animatedly with visitors and their relatives and saw they were encouraged to join in with activities.

Good

Is the service responsive?

Our findings

There had been no new admissions since our last inspection of the home. The registered manager showed us new documentation the provider had introduced to improve pre-admission assessments and made sure people's needs were fully assessed before admission. We saw this new documentation had been used to review the needs of people who currently used the service to make sure there was an up to date assessment of need. Information gathered in this assessment showed the provider considered the dependency of people who used the service. The registered manager said this was then used to review staffing levels to make sure they were appropriate to meet people's needs. They also said they were reviewing their admissions criteria for one of the units in the home and were working collaboratively with the local authority commissioners on this to ensure they could meet the needs of people referred to them in the future.

We looked at care plan documentation for 17 people who used the service and could see that improvements had been made since our last visit to the service. The majority of care plans we looked at were tailored to the individual and reviewed on a monthly basis or sooner if people's needs changed. We saw people had life histories completed with details of preferences and how individual choices were made. We saw some good detailed plans; for example, skin integrity, maintaining personal safety and mobility.

Staff told us they read the care plans to make sure they knew as much about people who used the service as possible. New staff told us if they were unsure of people's care needs they would refer to the care plans as they had the information they needed in them. One staff member said, "Everything we need to know is in the care plan."

However, we saw some care plans did not always fully reflect the needs and support people required. There was some confusing information in some people's plans that could have led to people's needs being missed or overlooked. For example, one plan did not state whether a person was to be weighed weekly or monthly; they were being weighed weekly. Another had confusing language such as 'mania' and 'agitation' and did not describe what this meant for the person. We also noted on occasions that review dates were missed off plans, making it unclear when they were due to be reviewed.

The care records were bulky, complex and difficult to navigate as we pointed out at our last inspection visit. We saw at times that old care plans had not been removed, making it unclear if they were still in use. For example, a covert medication plan and a behaviour support plan that was no longer relevant. The registered manager said the provider had acknowledged the complexity of the current care plan documentation and had developed new documentation that was currently being trialled in a number of the provider's other services. They said they expected introduction of this new documentation in January 2015 and training on its use would be provided.

We saw people were offered a range of social activities which included: reminiscence of the 1940's, 50's and 60's, sports quizzes, table games, sing-a-longs, armchair exercise, history club, nail art, memory boxes and one to one time, which could include shopping. We saw there were occasional entertainers on too. We spoke with activity co-ordinators and found them to be knowledgeable and enthusiastic about their role. They said they were trying to find out what people liked, what they were interested in so they could tailor activities to meet people's specific wants and needs. One staff member spoke of introducing taped books for someone who had sight problems and introducing themed corridors to enable people to find their way around more easily.

People who used the service told us they were happy with the activity on offer and they had enough to do. Visitors spoke enthusiastically about activity at the home. One person said, "There is always something going on; they go on trips, sometimes one or two go to the supermarket round the corner, they play games and so on. It's not all sitting round watching television." One person told us they enjoyed their own company and could organise what they wanted to do themselves. They did mention that they didn't like a day time television programme that they found offensive. They said they wondered if any of the people who used the service watched this or was it just left on. We discussed this with the registered manager and were told there was documentary evidence that a number of people liked this show.

We saw activity was meaningful and engaging and people who used the service were animated and appeared to be enjoying it. We observed a reminiscence based group discussion, and an afternoon tea. People who were dozing or not joining in had staff with them to chat to when they

Good

Is the service responsive?

wished. In another unit we saw a large group of people who used the service were being led by three staff in a sing-along, with the staff being animated and encouraging participation.

People we spoke with or their relatives told us they had no complaints. They said they would speak with staff or the manager if they had any concerns and they didn't have any problem doing that. They said they felt confident that the staff would listen and act on their concern. A relative told us how the service had responded in providing different moving and handling equipment when it was expressed that their family member was not comfortable with what was being used. The person who used the service said how much better they felt with this new piece of equipment. Another person who used the service said, "I can go and discuss things with them any time. I regularly go to [Name of manager] and have a chat with her."

People who used the service confirmed that the management of the home did seek feedback, and visitors told us they had attended a 'residents' meeting. One said, "It was lively and I think that they did listen. I have confidence that things would happen as a result." Another relative said they thought the meeting was very good. They said it had purpose and was constructive. During our visit we saw a relative had some concerns about a missing item and their family member's health. We saw they addressed this with the unit manager and were satisfied with the response they received. The relative told us, "I was quite happy to ask them about these things, I've no worries talking to them."

The registered manager told us that the management team listened and acted upon all complaints from people who used the service, staff and visitors. This was confirmed by all of the people we spoke with. This was also evidenced by copies of the complaints log, which detailed the specific issue, the investigation, the outcome, the actions that had been taken to resolve the issue and the escalation process, if required. This meant that complaints were dealt with to minimise the risk of the same issue arising in the future.

We saw systems in place to review learning from complaints. We saw evidence to show these had been communicated to staff through team meetings, to ensure improvement was driven through the organisation.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a clinical services manager, unit managers and a team of registered nurses and care staff. People who used the service and their relatives spoke positively about the management team and indicated that they could talk to them with ease. They told us the unit managers; registered manager and senior management team were approachable and listened to what they had to say. One person said they knew the registered manager well and felt they could speak with them if they needed to. Another person spoke of a unit manager, they said, "[Name of manager] is absolutely fantastic, nothing is too much trouble for him."

Relatives of people who used the service said they felt that there were efforts to engage with them, and several had attended a 'residents' meeting. No one told us they felt that there were things about the running or experience of the home that they wanted to challenge, but all felt that there would be action if they raised any concerns. A visiting health professional told us they had no concerns about the service. They said they found staff helpful, open, honest and transparent.

Our observations showed unit managers maintained a highly visible presence, interacting with people who used the service and assisting with tasks when required. Staff spoke positively of the culture in the units; they said there was a friendly, open culture and they felt comfortable approaching unit managers and nurses for any support. On one unit, two staff said they felt nursing staff could be more helpful and involved in providing day to day care and support. However, other staff said nursing staff were very helpful and gave a lot of support. One said, "Managers and nurses are all very approachable, can always ask for help if needed." Another staff member said, "The unit manager is very approachable, seems to be experienced, she always responds positively and gets involved with the residents."

Staff said they were aware of their roles and responsibilities and knew they were accountable for their actions. Staff said they would question practice if they felt they needed to and would feel confident to do so. Staff were aware of the whistle blowing procedures should they wish to raise any concerns about the organisation. They said the management team were receptive to providing any specialist training needs as they arose. They also said they had regular contact with the registered manager. One said, "[Name of registered manager] comes across quite often. She usually calls on a morning." A unit manager we spoke with said, "I see the clinical services manager daily and the registered manager is always accessible in the office or by phone, there's always someone there."

A number of staff we spoke with told us they liked working at the home because they enjoyed working with the people living at the home and felt well supported by all members of the staff team. Comments included; "I'm happy, very happy, I've been here 22 years", "I enjoy my job" and "I am very happy, therefore I have increased my contracted hours."

We saw a copy of the 'Statement of Purpose', 'Service User Guide' and 'Philosophy', which explained the provider's vision and values, how the home was managed, what people could expect, the provider's policies and practices and how complaints could be managed. During the inspection we saw the registered manager and care staff worked within the framework described in the booklet, which helped to provide a consistent level of care and support. Discussions with staff confirmed they understood the values which underpinned the philosophy of the home. A staff member told us, "Everybody knows each other and talks to each other."

People who used the service were supported to be involved in the running of the service through monthly meetings. We looked at some of the minutes from these which covered a number of areas such as: news related to the home/provider, property issues, housekeeping, catering, activities, care plan reviews, staffing, recognition for personal best, forthcoming training, regulator feedback, customer satisfaction action plan and complaints/ compliments. The meeting minutes also showed a range of issues had been discussed. These included refurbishment of rooms, food had been praised and comments regarding the activities co-ordinator, for example, "Noticeable difference since she started." There were also comments regarding a newly appointed unit manager; "Things have been improved with [name of unit manager] being in post." We also saw evidence of changes that had been actioned as a result of people's requests. The views of relatives had also been sought through a recent survey and the results were imminently awaited. We saw the actions from last year's survey had been signed off as addressed.

Good

Is the service well-led?

Effective mechanisms were in place to communicate key information to staff to ensure standards of care were maintained/improved. Management and staff meetings were held monthly and documentation showed these were forums for communicating key information to staff. We looked at the staff meeting minutes and noted that care issues were discussed and solutions documented to ensure all relevant staff were consulted and informed about any changes to improve the care provision. This also ensured that any key risks were communicated to staff about people who used the service. Staff meetings gave opportunities for staff to contribute to the running of the home. Staff we spoke with confirmed that these meetings took place on a regular basis. We were told that staff were able to raise issues and that concerns were addressed by the management team. This meant that staff were supported to give their views and were listened to.

These meetings showed evidence that practice was challenged and the provider was seeking to improve the skills and competencies of staff, such as supporting them in areas such as 'person first training'. The registered manager told us that 'Person First … dementia second' training provided an essential grounding in the principles of person-centred care.

The registered manager told us that they recognised the need to ensure the care and support delivered in the home was of high quality, therefore 'Take 10' meetings were held every day with heads of the departments to ensure this was achieved. This was evidenced by minutes from the 'Take 10' meetings. This included discussions on dependency of people who used the service and adequate staffing resources.

Systems of quality assurance were in place to monitor whether the service was providing high quality care. The registered manager told us that the unit managers discussed the following aspects of care on a daily and weekly basis: pressure area care/wound management; falls; nutrition/hydration; medicines management; infection and accident/incidents. We saw evidence that the registered manager analysed accidents, incidents, near misses and falls on a monthly basis and checked the actions were completed and effective. The registered manager showed us that action plans were reviewed/ signed off by the unit managers, area manager and quality manager when completed. This ensured that the service learnt from incidents to protect people from harm and indicated the registered manager was striving to continuously improve practice in the home.

The registered manager told us that they and the quality manager, area manager, clinical services managers and specialist nurse all had a role to play in the provider's quality monitoring system. We saw the results of a continuous programme of checks undertaken by various members of the management team. These included audits on care plans, medication, infection control, dignity and dining.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.**