Rotherwood Healthcare (Hampton Grange) Limited

Hampton Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 01 February 2017.

Hampton Grange Nursing Home provides accommodation, nursing and personal care to a maximum of 42 people, divided over two floors. At the time of our inspection there were 37 people living at the home. Some people were living with dementia.

Since our last inspection, there had been a change of provider and this was the first inspection since that change took place.

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

The provider had failed to effectively assess, monitor and improve the quality and safety of services provided. Though the provider had some systems in place to record and monitor the standards of care delivered within the home, these were not always effective. This followed our observed concerns about how some staff responded to the needs of people living with dementia during our visit. This also included that some staff had not received training to support people effectively at times, such as with a personal care needs. Whilst the home was very progressive in some area of dementia care, that was not always clearly demonstrated by staff. We also identified concerns about how some information was not always recorded accurately on both electronic and paper records. Individual concerns were not always effectively communicated at 'staff handovers' in addressing people's needs. None of these issues had been identified by the registered manager through the provider's own quality audit checks, nor had steps been taken to address these issues.

We have made a recommendation about environments used by people with dementia.

Staff did not always effectively support people who were displaying behaviour that was challenging, which impacted on other people present. People's privacy and dignity was not always respected. Staff were overheard speaking indiscreetly about people's personal needs. White boards in people's bedrooms detailed confidential and personal information, which was visible to people walking along the corridor. People were unable to go to the bathroom when they wanted, as staff some staff lacked suitable training in supporting people.

Records were not always up to date and accurate such as re-positioning charts and fluid intake and output charts.

Risks to people's safety were assessed and minimised.

There were enough staff to support people safely at the home. People considered there were enough staff and did not feel they had to wait too long to receive support from staff.

We found appropriate Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained, before staff started working at the home. Staff told us checks were made to make sure they were suitable to work with people before they started to work at the home, which included references, and a satisfactory DBS check.

The provider had appropriate arrangements in place to manage medicines safely. People were supported to take their medicines as prescribed.

Staff received regular supervision and training appropriate to their roles.

We found people's mental capacity to make decisions had been assessed and appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made. Care and support was provided in line with the recommendations within people's DOLS.

Individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and hydration risk assessments had been undertaken by the service, which detailed any risks and level of support required by people. Relatives told us they had been involved in providing information for a 'Diet Notification Record,' which included any dietary restrictions, any assistance required or specialised crockery needed by the person and preferred foods and drinks. We looked at weight and fluid intake records for people, which reflected they were receiving the type of diet they required, together with plenty of fluids

The provider supported people to access a variety of health professionals to ensure they received effective treatment to meet their specific needs.

People were happy with the standard of support they received and spoke positively of their relationships with staff. People and relatives were actively involved in making decisions about their care and were listened to by the provider. The provider routinely and actively listened to people to address any concerns or complaints. Where complaints been received they been managed in line with the provider's policy. Annual questionnaires were sent out to people to comment on the quality of services delivered.

People told us that both staff and the management team were very approachable. Staff told us the culture of the home was open and transparent and were confident that they would be listened to if they raised any concerns with a management about the service.

We found a 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 the 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?

Good

The service was safe.

People's risks were assessed and action taken to minimise risks to them.

The provider ensured there were enough staff on duty to meet people's needs.

The provider carried out appropriate checks when recruiting new staff.

Staff followed medicines management procedures to ensure people received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge needed to meet people's individual needs.

The provider had assessed and managed any risks associated with people eating and drinking.

Staff supported people to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff failed to respond to a person becoming anxious and agitated and the impact that would have on other people present.

Private and confidential information could be seen in people's rooms from corridors with little regard to people's privacy and dignity.

Staff demonstrated a good knowledge of the people they supported.

People and relatives were involved in making decisions about their care and were listened to by the provider.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People with behaviour that was challenging were not always supported effectively.

The home did not have adequate signage features that would help to orientate people living with dementia.

People were asked to provide feedback on the care given and to make suggestions on how services could be improved.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to effectively assess, monitor and improve the quality and safety of services provided.

Staff told us the culture of the home was open and transparent and were confident that they would be listened to if they raised any concerns.

There was a clear management structure in place and staff were aware of their roles and responsibilities.

Hampton Grange 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 01 February 2017 and was unannounced. The inspection was carried out by one inspector, a specialist advisor in nursing and an expert by experience. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection. The specialist advisor was a nurse with experience in elderly care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for any information they had, which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with the nine people who used the service and three visiting relatives. Many of the people we spoke with were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between staff and people who used the service. Some people were unable to speak to us, so we used the Short

Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received.

We reviewed a range of records about people's care and how the home was managed. These included five care records, medicine administration record (MAR) sheets, 10 staff files, quality assurance audits and minutes from resident and staff meetings.

As part of the inspection, we spoke with the registered manager, the regional manager, the deputy manager, the provider's resource manager, the training coordinator, three nurses, five members of care staff, two members of the activities team, the cook, domestic and the maintenance person.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us that they or their family members were safe living at Hampton Grange Nursing Home. One person said, "I do feel safe living here. No one wanders into our room. There are some people who have dementia and shout out, which is a bit off putting. The staff are genuinely nice and kind, some are exceptional." One person told us that there was always someone (staff) there for them and went on to say, "I think it's safer here than in hospital." A third person told us, "I'm alright here. The staff are always popping in and out. I see more people here than I ever did at home. The carers come round at night and pop their heads round the door, but the door shuts with a bang. I wish they could shut it more quietly."

We looked at how the provider ensured there were sufficient numbers of staff to meet people's needs and keep them safe. People considered there were enough staff on duty and did not feel they had to wait too long to receive support. The registered manager told us that over recent months, there had been issues with maintaining staffing levels, due to a number of staff leaving their employment at the service. In response to this they had sought agency staff to ensure people's needs were effectively met, however, the provider had now successfully recruited additional nurses and care staff. The registered manager told us that they were confident moving forward, there would be a significant reduction in the use of agency staff.

We asked staff for their views on staffing levels. One member of staff said, "At the moment staffing levels and the skills mix is not too bad. If we are short the registered manager will always arrange replacements. Staffing levels are safe and so are the people living here." Another member of staff said, "Staffing levels have improved, we are less reliant on agency." Other staff told us that with the current numbers of people residing at the home, staffing levels were sufficient. However, if occupancy numbers were increased to the home's maximum capacity, then additional staff would be required. The registered manager told us they believed the current numbers of staff were enough to be able to meet everyone's needs. They went on to say that staff numbers would be increased should the number of people living at the home increase.

We checked to see how people who lived at the home were protected against abuse. Safeguarding procedures are designed to protect people who use services from abuse and the risk of abuse. Staff told us they had received training in how to recognise when people were at risk of abuse. Staff were able to confidently describe what action they would take if they had any concerns and were aware of the provider's whistleblowing procedures. One member of staff said, "We have safeguarding policies and procedures here and if I thought there were any concerns I would report to the manager. I would also report to a higher authority, such as the local safeguarding team, if my concerns were not addressed. We are here to safeguard every one living at this home." Another member of staff told us, "I would pass on any concerns to the nurse or manager and write up the incident report and ensure action was taken. We also have an 'education board' here, which contains details of our whistleblowing procedures."

We found the provider had safe recruitment procedures in place, which ensured staff were suitable to support people who used the service. This included appropriate checks carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. We found Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained. The DBS helps employers to make

safer recruitment decisions. Staff told us checks were made to make sure they were suitable to work with people before they started to work at the home, which included references, and a satisfactory DBS check.

The provider had assessed, recorded and kept under review the risks associated with people's individual care and support needs. People were supported by staff who understood and managed risks associated with people's care effectively. Staff told us about people's health needs and how they managed risk, which included actions they would take to reduce or minimise the risks. This included action in relation to falls, choking, skin integrity, nutrition and hydration. One member of staff explained that the provider had recently introduced a system of designated 'champion' roles for staff and they had become the 'hydration champion.' They described their role as having responsibility for ensuring people at risk received sufficient hydration during the day with a view to preventing infections. They monitored people's fluid intake during the day using hand held electronic devices and were always considering new ways to ensure staff 'pushed fluid.' Other 'champion roles' to be introduced included mobility and falls, skin integrity, continence and person centred care and activities. One member of staff also told us, "Risk assessments are in everyone's care plan. For example, one person has no capacity and is unaware of their environment and surroundings and associated dangers. There is an action plan in their file, which includes a pressure alarm mat in their room and when they are in the lounge. We are notified straight away if they are moving about as they are at risk of falls, so we can make sure they are safe."

If people were involved in any accidents of incidents, staff understood the need to record and report these matters. We saw that accidents and incidents were recorded electronically and within people's care files. The provider then used this information to identify underlying trends in an effort to reduce risks to people and prevent reoccurrences, such as falls.

We found people's medicines were managed safely. We observed the process of administering medicines to four residents who were in their own rooms. The nurse had a good knowledge of people's care needs and their preferences. They confirmed they had received training in the safe administration of medicines. We checked people's medicine records and looked at the medicine storage arrangements. The provider had put systems and procedures in place that reflected good practice, and were designed to ensure people received their medicines safely.

We looked at the controlled drugs register and saw that stock was checked daily by two nurses. We undertook a stock take and found the number of remaining tablets were correct. Accurate medication administrative records (MAR) were kept. Staff also used the reverse of the MAR to record (using a key) for other transactions. For example, recording the fact a person had requested and been given paracetamol at a specific time. Medicines received from the pharmacy were counted and recorded on the MAR chart. The registered manager carried out a monthly audit of medicines and recorded any actions required. The provider was also audited by the pharmacy that provided people's medicines. Where any shortfalls had been identified on any of the internal or external medicines audits, actions been taken to address the issues.

Good

Is the service effective?

Our findings

People were supported by staff who were trained to support them effectively. Staff told us they completed a range of training, which was appropriate for their individual roles. Care staff told us they were encouraged to develop and increase their knowledge beyond the daily requirements of their role, following the recent introduction of 'clinical assistances and 'champion's roles.' Care staff told us that the provider had recently introduced the roles of clinical assistant and a 'champion's role' in specific areas of care. Staff told us the role of 'clinical assistant' was to enable them to provide practical support to nurses, whereas the 'champion's role' enabled them to develop knowledge in a specific areas, such as hydration, nutrition and skin integrity. The member of staff who had responsibility as 'champion' for nutrition, told us they were due to attend a nutrition course for people with dementia.

The deputy manager told us that they had developed a more person centred care approach with staff, which required training and development. They told us they had found the provider had been very supportive with any new ideas, such as the introduction of new roles for staff and the additional training required. These roles were gradually being introduced over a period of time.

New staff told us they all attended a period of induction, structured around their previous experience. Staff with no previous experience of working in care were also required to complete and meet the required standards of the care certificate, before working independently. The Care Certificate is a nationally recognised training programme for care staff. One member of care staff told us they received annual training the provider considered essential for their roles, which included both class room based training and on-line training. They told us they had recently undertaken practical training in moving and handling and classroom based training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff said, "If we request specific training they are all for it. I'm currently doing a clinical assistants course, which will allow me to be able to support nursing staff more effectively." Another member of staff told us, "I do feel we get sufficient training in our role and I have also been promoted to clinical assistant and due to shadow a nurse and be assessed. I'm awaiting to have my competency signed off by the manager."

One recently recruited nurse, told us their induction included meeting all of the people who lived at the home and reading a range of the provider's policies. They had undertaken a period of 'shadowing' (working alongside) more experienced staff and completed manual handling training. Since starting at the home, they had completed 16 training courses, which included safeguarding, medication and MCA. They felt very supported with any requests for additional or specific training and that they had recently requested phlebotomy training, which has been arranged for March 2017. Several nurses we spoke with told us English was not their first language. One nurse told us their command of the English language was not good and that they had been encouraged to commence classes locally to improve it. This was to enable them to communicate with people living at the home more effectively.

We asked staff about the support, supervision and annual appraisal they received. Supervision and appraisals enable managers to assess the development needs of their support staff and to address training and personal needs in a timely manner. Staff told us they received regular one to one supervision and felt

valued and supported by the management team. One member of staff said, "I feel very supported and if I had any concerns I would approach the manager or the nurse in charge. I get supervision every three months, where I can request training and we review my performance." Another member of staff told us, "We have three monthly sit downs with management for about 30 – 40 minutes. We discuss any worries, how I'm getting on and any training requirements. We also reflect and discuss any training I have had."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people's mental capacity to make decisions had been assessed where needed and appropriate DoLS applications had been made. Care and support was provided in line with the recommendations within people's DOLS.

DNACPRs (Do Not Attempt Cardiopulmonary Resuscitation) were in place and recorded professional and family discussions and decisions. Most staff were able to demonstrate that they had knowledge of the principles of the MCA and confirmed they had received training in the MCA.

During our inspection we checked to see how people's nutritional needs were met. We asked people what they thought of the food they received. One person said, "There's a lot of things I don't eat, but there's always an alternative. Sometimes the cook comes in and offers me a steak, the others can't chew it. And they make me my favourite, which is a ploughman's." Another person told us, "The food is very good, and it's always nice. There's more than enough choice, but there's a lot of waiting." A third person said, "The food is very good, you can't complain about the food. There's always a good variety."

We saw that menus were planned in advance on a seasonal four week rotation. Meals were cooked on the premises with kitchen staff on duty to cover all meals including the evening meal, which was freshly prepared rather than being prepared in advance. On the day of the inspection, we noticed that people were given choices at both breakfast and lunch time. At lunch time a choice of roast pork or a vegetarian bake were available with vegetables. If people did not want items from the standard menu, the 'Alternative Snack Menu' listed sandwiches, jacket potatoes with various fillings and other options available.

We observed the lunch time experience, where the main meal was served from a heated trolley. We heard one person say, "I like this, it's nice and hot". The food looked appetising and tables were laid with cloths and fresh flowers. Staff offered people a choice of fruit juices and offered help with cutting up their meat. Staff gave people plenty of encouragement and any physical assistance needed to eat and drink safely and comfortably. The meal time experience was relaxed and calm, but we did notice that there was considerable delay before dessert was served. Staff waited until most people had finished their main course before offering puddings during which some people became restless. We spoke with the registered manager who told us they would review the meal time service following the inspection. People received plenty to drink and there were snacks available during the day, which were suitable for people needing a soft diet.

People's individual nutritional needs were assessed and planned for by the home's staff. We saw that

nutritional and hydration risk assessments had been undertaken by the service, which detailed any risks and level of support required. Relatives told us they had been involved in providing information for a 'Diet Notification Record,' which included any dietary restrictions, any assistance required or specialised crockery needed by the person and preferred foods and drinks. We looked at weight and fluid intake records for people, which reflected they were receiving the type of diet they required, together with plenty of fluids. People at risk of malnutrition had been referred to dietician services for further advice. Senior care staff also had the role of 'Domestic Hostess.' This involved directly liaising with kitchen staff in respect of people's allergies, likes and dislikes and dietary requirements. The 'hostess' plated up the food at meal times for the individuals in their care. Staff told us this was to minimise the likelihood of people being given the wrong food that was 'bad for them' or 'what they did not like.' One member of staff told us they knew exactly who was eating well and who wasn't eating so much, which enabled them to report any concerns to nursing staff.

We found people received effective support to access a variety of health professionals to make sure they received treatment to meet their specific needs. These included GPs, optician and diabetic nurses. Staff monitored people's health on a day-to-day basis and accessed healthcare services if there was a change in people's conditions. One member of staff told us, "People are supported to access a number of multi-disciplinary teams, such as GPs, dentist, hearing, tissue viability, Parkinson nurse and speech and language therapists (SaLT)."

Requires Improvement

Is the service caring?

Our findings

People and relatives told us they were happy with the standard of support they received from staff. One person told us, "Generally, the staff are kind, but like most things, some are better than others." Another person said, "The staff are very nice and they're a jolly lot". One relative said, "The staff are excellent. They help when needed and you never have to ask twice." A third person said, "The staff are very good, they are all excellent. Nothing's too much trouble for them." one relative told us, "I feel this is a very good home and we are very happy with the place. We are very pleased (relative's name) is in a good home." Another relative told us, "They're brilliant. My (family member) is very happy and if they're happy, then as a family, we're very happy. The staff are very friendly, they are like family friends. My relative always seems to have enough staff around to meet their needs, but I would like to see more local people." They then explained about their concerns about language and communication problems with staff whose first language was not English, and who lacked a shared knowledge of the local area when engaging with people.

Both people and relatives told us that friends and families were always made to feel welcome and were invited to join in special lunches, such as Christmas. Another relative said, "My family visits and they're always offered teas and coffees. I think (family member) only comes for the tea and cake. My family are very content."

People looked well-groomed and were appropriately, but individually dressed in their clothing that was clean and tidy. People looked content and were confident in their exchanges with staff. However, in the day room after lunch, we saw one person who was living with dementia, say to the member of staff present, they wanted their hair done. They were not in any way responded to or acknowledged by the member of staff, who continued engaging in an activity with other people involving patting a balloon. This person became increasingly agitated and worried about personal matters, which they addressed towards the member of staff. It was only when a further member of staff arrived in the room, that the person was attended to with reassurance and told their hair would be done, and not to worry. Though the first member of staff was engaging with other people in activities, they failed to identify and respond to the fact the person was becoming increasingly anxious and agitated. This impacted on the tranquillity of others who were in the room at the time.

People's privacy and dignity was not always respected. During our visit, a member of staff required urgent support with a person who was unwell in their room on the first floor. Care staff in the main lounge went to assist leaving a member of the activities team to supervise people. One person indicated that they wanted to be taken to the toilet. The member of the activities team present told us they were not trained to deliver personal care. They asked colleagues to find a member of the care staff team to help the person. Assistance was still being sought 15 minutes later. The member of the activities team told us, "Sometimes I wish we (activities staff) were trained to take people to the toilet in emergencies. I think some residents think it is degrading not to be taken to the toilet as soon as they need it. They worry about having an accident. There's a fine line between activities and caring."

People told us that staff were respectful. One person who lived at the home told us, "They're all very

respectful to residents. They speak nicely to them and treat them all as individuals, which is nice." Personal care was carried out behind closed doors and staff were seen to knock on doors before entering rooms, even when the door was open. On the whole, staff were discreet when supporting people to go to the toilet, however we heard one member of who spoke loudly when telling colleagues that they were taking the person to the toilet, without awareness of the person's privacy and dignity. In bedrooms we saw white boards, which were displayed on the wall facing the door. These boards could be read by anyone passing along the corridor. The white boards detailed confidential and personal information about the person residing in the room, with little regard to their personal privacy and dignity. We spoke to the registered manager about these matters, who told us these concerns would be addressed.

People told us staff encouraged them to be as independent as possible. One person told us, "I get up about 5am and I'm a smoker so, when I'm washed and dressed, they take me out for a cigarette and a cup of tea. They really are very good. I can wash and dress myself, I choose my own clothes and they help me shower and bath. I just ask them the night before." Two people with restricted mobility, told us that they liked to wash and dress themselves although staff would help them to take a bath or a shower.

Staff were seen to encourage people to do as much as they could for themselves so as to retain their dignity and sense of independence. For example, people who were safe to do so, were supported to stand to improve their muscle strength and coordination rather than using equipment such as a hoist to help people. People were also encouraged to move from armchair to wheelchair with the aid of a walking frame and when required the support from staff. One member of staff told about the support they provided to a person with limited eye sight. They would place a spoon in their hand and guided them to feed themselves. They said, "I encourage people to be as independent as much as possible as it provides them with a quality of life and their self-esteem is better."

Staff we spoke with demonstrated a good knowledge of the people they supported. Throughout the course of the inspection we saw regular engagement between staff and people. Staff interacted with people throughout the day and it was clear that they had a good understanding of people's needs. We observed many occasions where staff spoke privately on a one-to-one basis with people. We saw many warm spontaneous exchanges between staff and people. One person gave a member of staff a little kiss on the cheek and the staff member replied by saying, "Oh thank-you (name of person), that was lovely." We saw a nurse give a person a hug when administering their medicines.

Staff told us how they had completed a 'Map of Life' with people and their family, which provided information such as where the person was born, where they grew up, brothers and sisters, employment, marital status, any children and/or grandchildren, other close relatives, pets and favourite TV programmes. They also compiled a list of people's 'Favourite Things,' such as colours, smells, flowers, books, perfume or aftershave, the clothes they preferred to wear, cosmetics and sweets. Staff told us this information was used to ensure people's preferences were respected.

People and relatives told us they were involved in making decisions about their care and were listened to by the provider. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place. One relative said, "They do keep me involved, we have meetings each year to review my relative's care."

Requires Improvement

Is the service responsive?

Our findings

During our inspection, we found some people were living with dementia. We saw limited evidence of dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. We did not see any facilities such as 'rummage boxes, with tactile items or other items of general interest around the home for people living with dementia to pick up and investigate. We found the home did not have adequate signage features that would help to orientate people with this type of need, such as memory boxes outside their room or bathrooms clearly marked.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

People told us the service they received was responsive to people's needs and nothing was too much trouble. One person said, "I feel they are responsive to anything we need." A visiting relative described staff as, "Nothing too much trouble, always happy to do things for you."

The resources manager told us they used a national recognised programme that played an important role in providing a 'dementia-friendly' living environment for people. When people were confused and anxious, they used personalised aromatherapy oils to soothe people who were agitated either in the form of a spray or a hand massage. This enabled one to one engagement with staff with the additional benefit of relaxing joints and improving joint mobility, improving skin condition and promoting relaxation. Warm lavender scented damp flannels were also available for people to hold for comfort purposes. There was a designated salon in the home, where people could be treated as if they were in a spa.

Care and activities staff told us they had received training in dementia care and were aware of the programme followed at the home to support dementia care. However, we did not see any reflection of this programme in use by staff when dealing with two instances of people who displayed behaviour that was challenging. One incident involved a person who was agitated and was shouting loudly and repeatedly. Staff were aware of this person and made a brief visit to their bedroom, before leaving the person alone in their room, where the shouting continued for some time. This impacted on other people who were in neighbouring bedrooms at the time.

During our visit, we noticed that call bells were ringing continuously throughout the day, which may have been unsettling for people living with dementia. We asked one person if staff responded quickly if they called for help. They replied, "Oh yes. I don't know anything about people being neglected or bells not being answered. I think staff are really pushed sometimes. It doesn't affect me or any of the residents, but these girls (staff) must get absolutely shattered." We saw a nurse directing staff to respond to specific call bells and questioned why other staff were not responding. The nurse explained that staff were allocated to individual floors and would only respond to call bells on their allocated floor, unless directed to otherwise. We spoke to the registered manager about the continual ringing of call bells and the impact the sound may have had on some people living with dementia. They told us they would review the current system with the provider

People's care and treatment was provided by a staff who were able to describe people's needs and abilities. This was reflected in the care plans we looked at, which were both electronic records and paperwork. People had their needs assessed before moving in, which involved a meeting with the person, their relatives and liaising with other professionals involved in their care. This ensured that the provider was aware of people needs and the skills required to support them. Support plans provided clear instructions to staff of the level of care and support required for each person, however, were not always up to date with accurate information. In some care plans we looked at, we saw evidence that indicated inconsistent recording of re-positioning and fluid intake and output charts. We asked the deputy manager how they dealt with these issues. They told us any concerns would be raised at staff handovers. We looked at the recordings of 'handovers' made for the dates in question, and saw that no reference had been made to poor record keeping.

People told us there were plenty of things to do. One person told us that they were quite happy in their room with their TV and they liked reading books that friends brought in. One relative said, "They have opportunities and choices of what they want to do." The home had links with local churches and a local vicar held monthly Holy Communion services in the home. We saw activities staff engaging with people in games, colouring and chatting in the lounge. People who choose to stay in their rooms, told us staff visited them in their rooms for a chat, which they really enjoyed. Staff told us people joined knitting and flower arranging groups at the home.

Activities staff told us about a drinks trolley system that had been introduced. During the morning, members of the activity team had responsibility for providing fluid to people who were in bed. The tea trolley was nicely presented with suitable crockery and staff were seen to spend time with people in their room encouraging them to drink and making the task an opportunity for one to one engagement and socialisation.

The registered manager routinely and actively listened to people to address any concerns or complaints. There was a complaints policy in place, which clearly explained the process people could follow if they were unhappy with aspects of the service. People told us they would not hesitate to raise any concerns with staff. Where complaints been received they been managed in line with the provider's policy. Annual questionnaires were sent out to people to comment on the quality of services delivered. At the time of our visit, the responses had yet to be analysed by the provider.

Families were invited on to the Nutrition Steering Group and to Family Support Group meetings. They were asked to provide feedback on the care given to their relatives and to make suggestion to improve services, such as the quality of menus. Nutritional Steering Groups consisted of representatives from nursing, care, catering, activities, residents and families. Minutes we looked at discussed fortified snacks, such as enriched yogurts, fortified sandwich fillings and smoothies, which were available for people identified as being at 'nutritional risk' and should be offered between meals

Requires Improvement

Is the service well-led?

Our findings

Though the provider had some systems in place to record and monitor the standards of care delivered within the home, these were not always effective. This followed our observed concerns about how some staff responded to the needs of people living with dementia during our visit. This also included that some staff had not received training to support people effectively at times, such as with a personal care needs. Whilst the home was very progressive in some area of dementia care, that was not always clearly demonstrated by staff. We also identified concerns about how some information was not always recorded accurately on both electronic and paper records. Individual concerns were not always effectively communicated at 'staff handovers' in addressing people's needs. None of these issues had been identified by the registered manager through the provider's own quality audit checks, nor had steps been taken to address these issues.

This was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This was because the provider had failed to effectively assess, monitor and improve the quality and safety of services provided.

People told us they were happy with the management of the home. Staff we spoke to acknowledged that there had been on-going issues with staffing, but things were settling down. Staff told us the culture of the home was open and transparent and were confident that they would be listened to if they raised any concerns with a management about the service.

One member of staff said, "We've now got stability and long term staff. The registered manager has worked together well to achieve this, but it's been difficult. There has been a period of change, but it's now more settled. The registered manager listens and hold regular staff meetings. Staff now have more training and had introduced a Deputy Clinical Manager. We're definitely building up on our team spirit. Staff will take residents shopping or to the garden centre even on their days off." Another member of staff told us, "I like the shift pattern, the people I work with. It's a really nice environment to work in, good experience in caring for people. I love all the residents and come in on my day off to take them out." A third member of staff said, "Management are very good and supportive and often on the floor. They do listen and take on board any concerns. There is a good culture here in my view, though not all staff are engaged unfortunately."

The provider had been in post since December 2015, and when we spoke to the registered and deputy managers, they described the home as 'work in progress.' They told us they were focused on delivering person centred care and had provided development opportunities for staff, which had been supported by provider. The deputy manager told us that they found the home very task focused when they first arrived, but things were more person centred now. They hoped to continue to make improvements in this area. Throughout our inspection visit, we saw the registered manager engaging with people and staff. There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff told us there were arrangements in place to support them, such as regular supervision and team meetings. Staff told us there was always someone available to provide advice and guidance.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of services provided.