Mellandene Limited

Cassandra House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 2 July 2015 and was unannounced. We previously visited the service on 3 December 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 42 older people, some of whom may be living with dementia. The home is located in Cottingham in the East Riding of Yorkshire and is also close to the boundary of Kingston upon Hull. It is situated in a quiet residential location but is reasonably close to local amenities. The home is located within its own grounds. Most people have a single bedroom and some bedrooms have en-suite facilities. On the day of the inspection there were 39 people living at the home permanently, and one person having respite care.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

People told us that they felt safe living at Cassandra House and we saw that the premises were being maintained in a safe condition. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident that any allegations of abuse or concerns would be dealt with professionally by managers, but they would not hesitate to use the home's whistle blowing policy if needed.

People told us that staff were caring and this was supported by the relatives and health care professionals who we spoke with. People who lived at the home, relatives and health care

professionals told us that staff were effective and skilled. Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training record evidenced that most training considered to be mandatory by the home had been completed.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home and to enable them to spend one to one time with people. New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with older people had been employed.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust. Staff that had responsibility for the administration of medication had completed appropriate training and the registered manager carried out checks to ensure staff remained competent to carry out this task.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided at the home. People told us that they had ample choice and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and we saw that any improvements that were needed had been actioned and were used as a learning opportunity for staff.

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?
The service is safe.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met.

The arrangements in place for the management of medicines ensured that people received their medication in a safe way.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home.

Good

Is the service effective?
The service is effective.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and people were supported to make decisions about their care.

The records we saw evidenced that staff had completed induction and on-going training that equipped them with the skills they needed to carry out their role.

People told us they had access to health care professionals when required.

People's nutritional needs were met, and people's special diets were catered for.

Good

Is the service caring?
The service is caring.

We observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that staff cared about the people they were supporting and people's individual needs were understood and met by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Good

Is the service responsive?
The service is responsive to people's needs.

People's preferences and wishes for care were recorded and these were known by staff. People's needs were continually assessed and updated.

We saw that people had been consulted about activities and, as a result, social activities were tailored to people's individual needs; people were encouraged to take part in activities and outings.

There was a complaints procedure in place and people told us that they were confident any comments or complaints they made would be listened to.

Good

Summary of findings

Is the service well-led?

Good

The service is well led.

The service was being managed by an experienced registered manager with support from a skilled deputy manager. Managers promoted a culture of openness and transparency.

The registered manager carried out numerous quality audits to promote the safety and well-being of people who lived and worked at the home.

There were sufficient opportunities for people who lived at the home, staff, relatives / friends and care professionals to express their views about the quality of care provided by the home.

Cassandra House

Detailed findings

Background to this inspection

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

The inspection took place on 2 July 2015 and was unannounced. The inspection team consisted of two Adult Social Care (ASC) inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authorities that commission a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. We also contacted a selection of health and social care professionals to ask for their opinions about the quality of the service provided at the home; we received responses from two health care professionals.

On the day of the inspection we spoke with four people who lived at the home, two relatives, three members of staff, the deputy manager and the registered manager. We also spoke with a visiting health care professional.

On the day of the inspection we looked around communal areas of the home and some people's bedrooms (with their permission). We spent time observing the interactions between people, relatives and staff in the communal areas, including during mealtimes. We observed the care and support being delivered in the communal areas of the service and we spoke with people in private. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with four people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did. One person said, "Yes, there are lots of carers, always somebody about night and day" and another told us, "Yes, nothing has ever frightened me, everyone is alright to get on with – lucky here." A relative told us, "I do feel the premises are safe."

Staff described to us how they kept people safe. One member of staff said, "We have a duty of care – (we are) always around if they need us, we are always checking on them" and another told us, "(We) make sure no objects can harm them, no hazards left out, and we use correct handling equipment." We saw that most staff had completed training on moving and handling, although there were a small number of staff who had not completed this training. On the day of the inspection we saw staff using safe moving and handling techniques and that appropriate equipment was used when staff assisted people with transfers.

Each person had an environmental risk assessment in place that measured any risks they encountered when using the premises or equipment; this included the risk of falls. We saw that care plans listed the risks associated with the care of each person under the heading 'risk and vulnerability'. These included risk assessments for aspiration, pressure care, use of a wheelchair, use of the bath hoist and malnutrition and referred to the possible outcome of risk assessments not being followed. One person's risk assessment recorded, "If (name) were to go out alone she would be at risk of falls, traffic, the elements and getting lost." Risk assessments were reviewed on a regular basis to ensure they were still relevant to the person concerned.

There were safeguarding policies and procedures in place. We spoke with the local authority safeguarding adult's team prior to the inspection and they told us about four safeguarding alerts they had received from the home; they did not express any concerns about how these situations had been managed.

Training records evidenced that all but three of the 37 staff employed had undertaken training on safeguarding adults from abuse during 2014 or 2015; this included ancillary staff as well as care staff. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any concerns. Staff told us that they would also use the home's whistle blowing policy if needed and that they were confident managers would deal with this information professionally. We saw that staff had been given a safeguarding survey to complete and one of the questions was about awareness of whistle blowing. This showed that managers understood the need to continually remind staff about safeguarding and whistle blowing policies and procedures.

On the day of the inspection we saw that there were sufficient numbers of staff on duty. We heard call bells sounding throughout the day and we noted they were responded to promptly. We asked people who lived at the home if they received prompt attention. One person told us, "Staff come straight away if I press the call button" and another person said, "Seems to be – sometimes a bit of a hold up." Staff told us that they thought there were enough staff on duty. One staff member told us, "Generally alright – fine at night too. If sickness, there is always someone to cover shifts" and another staff member said, "Good – I come if they need me at short notice." Relatives also told us they saw that there were enough staff when they visited the home. A health care professional told us that they could usually find a member of staff to assist them, but "Sometimes they had to spend time looking."

We asked the registered manager to explain the standard staffing levels. She told us that there was one senior care worker and four care workers on duty each morning, plus a senior care worker and the deputy manager in the office. In the afternoons / evenings there was one senior care worker and four or five care workers on duty. Overnight the standard staffing levels were one senior care worker and two care workers. When the registered manager was at the home this was in addition to these staffing levels.

There was an administrator working Monday to Friday plus ancillary staff; this included two cooks in the morning and one in the afternoon each day, two or three domestic staff each day (reducing to one on Saturdays and Sundays) and one or two laundry assistants each day. This level of ancillary staff meant that care staff were able to concentrate on supporting people who lived at the home and not on domestic or catering duties.

We checked a selection of staff rotas and saw that these staffing levels had been consistently maintained. The

Good

Is the service safe?

registered manager told us that they had discussed twelve hour shifts at a staff meeting and it had been agreed that this would be piloted, first with senior staff and then with night staff.

We checked the recruitment records for two new members of staff. We saw that people submitted an application form accompanied by a curriculum vitae (CV). Application forms included the person's employment history, the names of two employment referees and a declaration about any criminal convictions. The registered manager told us that they obtained a copy of certificates evidencing training previously completed by staff, but that they were still expected to complete the training provided by Cassandra House. We saw that the questions asked at interview and applicant's responses were kept for future reference, along with evidence of the person's identity. By following their recruitment and selection procedures, the registered person had ensured that only people considered suitable to work with older people had been employed.

We did not see the contingency plan on the day of the inspection but the registered manager explained the content to us. The plan included details of alternative accommodation that could be used in the event of an emergency. This was used to great effect when the home was flooded in June 2007. In addition to the contingency plan, people who lived at the home had personal emergency evacuation plans (PEEPs) in place. These are documents that record the assistance a person would need to evacuate the premises, including the equipment they use to mobilise and the level of assistance they would require from staff.

There were checks in place to ensure that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home. We reviewed a selection of maintenance certificates and saw that there was a current gas safety certificate and an electrical installation certificate in place, that portable appliances had been tested and that lifts and hoists had been serviced. The fire alarm system, emergency lighting and fire extinguishers had been serviced in January 2015 and the fire alarm system had been serviced again on 1 July 2015.

Whilst we were at the home we noticed that there was a pressure mat in a lounge area by the side of someone's chair. The mat was torn at the edges and the cord was trailing on the floor. There was also a footstool close by. We were concerned that this created a trip hazard. We saw that one person had three tubes of Steredent in their bedroom and that the door was not locked and the Steredent was not stored in a locked cupboard. We pointed out to the registered manager that there was a risk of someone inadvertently ingesting this product. Both of these issues were rectified by the registered manager whilst we were still at the home.

We asked staff if they thought the premises were suitable for the people who lived at the home. One member of staff told us that they felt the ramp near the manager's office was too steep. We were aware that the ramp had been in situ for many years and the registered manager told us that there had not been any accidents as a result of people using the ramp. However, the registered manager agreed to take further advice about the ramp from the local authority health and safety officer, and to act on their recommendations.

A person who lived at the home pointed out to us that there were no safety gates on the stairs. They were concerned that people who were living with dementia might fall down the stairs. The registered manager told us that they had considered installing safety gates, but they feared that some people would try to climb over them, and the hazard would increase rather than decrease. They told us that most people who were living with dementia were accommodated on the ground floor and they felt that this reduced the risk of an accident occurring.

We saw that the home had information in place about falls awareness and falls management in care homes, and that there were appropriate risk assessments in place. We also saw the records for accidents and incidents. The forms for each month were stored together and had been evaluated to identify how many accidents had taken place, how many people had been taken to accident and emergency departments, whether any incidents required a safeguarding alert to be submitted, were any accidents reoccurring and whether family had been informed.

Health care professionals told us that there were robust medication systems in place at the home.

We saw that there were policies and procedures in place on the safe handling of medication. An in-house stock check had been undertaken on 22 June 2015 and no discrepancies had been identified. We saw that an audit

had also been undertaken by the pharmacist who supplied the home with medication. They had made some recommendations about storage and there was evidence that these had been implemented.

There were two medication trolleys in use at the home and each was locked and fastened to the wall when not in use. One trolley was used to store the morning and lunchtime medication and the other was used to store tea-time and evening medication. Medication was supplied in blister packs and these were colour coded to identify the times that the medication needed to be administered; this reduced the risk of errors occurring.

We checked medication administration record (MAR) charts and noted that there were no gaps in recording. Each person had a laminated sheet to accompany their MAR chart. This recorded the person's date of birth, their GP and any known allergies and the person's specific requirements in respect of the administration of medication. For example, one person's sheet recorded, "(The person) would not be able to say if he was in pain so observation of facial expressions is needed" and another person's sheet recorded, "(The person) has an understanding of what his medication is for and would understand any medication changes. He is able to say if he is in pain or discomfort." People who we spoke with told us that they knew why their medication had been prescribed. One person said, "Yes, I wouldn't take them if I didn't know what they are for."

All staff that administered medication at the home had undertaken appropriate training. In addition to this, the registered manager told us that they checked staff competency and that this included the completion of a medication quiz. We observed the administration of medication and saw that this was carried out safely; the senior staff member did not sign MAR charts until they had seen people take their medication. People were provided with a drink of water so that they could swallow their medication. There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The deputy manager told us that GP's were asked to record any changes in medication on the person's MAR chart and we saw examples of this on the day of the inspection.

The deputy manager told us that they used a 'bleeper' to remind staff to administer any medicines that were not prescribed at the usual times. This ensured that people received the right medication at the right time.

The medication fridge was stored in the medication cupboard. We saw that fridge temperatures were checked and recorded each day to ensure medicines that needed to be stored at a low temperature were held safely. We checked the medication fridge and saw that it was only used to store medicines. The temperature of the medication room was also checked regularly and recorded.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in use balanced. We also checked the records for Warfarin; people who are prescribed Warfarin have to have a regular blood test and the results determine the amount of Warfarin to be prescribed. The deputy manager told us that the results of blood tests were faxed to the home and this information was recorded in the yellow book used specifically for this purpose. On the day of this inspection we noted that this recording was accurate.

We noted there was an effective stock control system in place and the deputy manager told us that the date was written on liquid medication to record when it was opened and the date it expired. This was to ensure the medication was not used for longer than stated on the packaging. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory; a specific returns book was being used that recorded details of the medication to be returned.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Although only a small number of staff had completed training on these topics, it was clear that managers and staff understood the principles of MCA and DoLS.

We saw a DoLS authorisation in one person's care plan and noted that this included information about the date the DoLS authorisation expired. The registered manager confirmed that another application had been submitted to the local authority for consideration.

People's capacity to make decisions had been assessed and care plans recorded the types of decisions people could make and the decisions that would need to be made in the person's best interest.

Some people who lived at the home were living with a dementia related condition, and eight people had a specific diagnosis. People told us that they could find their way around the building and we saw that some attempts had been made to enable people to orientate themselves around the home. There were signs to direct people to the dining room, toilets and bathrooms and some bedroom doors had people's names on them. Some coloured plates and cutlery had been purchased to help people with cognitive difficulties to identify food on their plate so they could eat independently. However, pictorial indicators needed to increase to assist people to recognise their own room and other areas of the home, and the décor of the home needed to be considered to make it easier for people living with dementia to orientate themselves around the home.

We saw that some carpets were heavily patterned and discussed with the manager how this could create anxiety for people with cognitive difficulties. They told us that they had identified this as a concern and the maintenance plan at the home included plans to replace patterned carpets with plain flooring.

At a staff meeting in June 2015 staff had discussed wearing pyjamas during the night to help people who were living with dementia to recognise it was night time. This was being trialled by night staff; they arrived at work in their uniform and put their night clothes on later, and changed back into their uniform in the morning when they started to assist people to get up. This indicated that staff were aware of some of the good practice guidance around the care and support of people living with dementia.

We asked people who lived at the home if they thought staff had the right skills to carry out their role. People were positive in their responses. One person said, "Oh crikey yes, definitely, there is always a lot of staff meetings so they know their job" and another said, "Staff really know what they are doing, I trust the staff." Relatives told us that staff seemed to have the right kind of skills to do the job. One relative said, "I think they do very well. I haven't seen one cross. I am relaxed about the staff."

Each member of staff had an individual training record in place and staff who we spoke with were able to tell us about training they had recently completed. This included mental health, fire safety, first aid, health and safety and National Vocational Qualification (NVQ) awards. The records we saw evidenced that new employees had completed induction training that included the topics of safeguarding vulnerable adults from abuse, infection control, moving and handling, fire safety, person centred care, first aid and dementia awareness. The registered manager told us that they had introduced the Care Certificate at the home to replace the Common Induction Standards. The Care Certificate had been introduced by Skills for Care, a nationally recognised training resource.

Staff told us that they shadowed experienced care workers as part of their induction training, and we saw that new staff were given a copy of the staff handbook and their job description; this meant staff would be clear about what was expected of them in their new role.

We asked the registered manager what they considered to be key training for staff. They told us that senior staff were expected to undertake training on medication, fire safety, moving and handling, safeguarding vulnerable adults from abuse, first aid, infection control and health and safety plus NVQ Level 3 in Health and Social Care (or equivalent). Care workers were expected to undertake the same training courses plus NVQ Level 2 in Health and Social Care (or equivalent). Ancillary staff were also expected to undertake training that the home considered to be mandatory. The

Good

Is the service effective?

registered manager told us that staff were expected to complete fire training every twelve months, safeguarding vulnerable adults from abuse every two years and the remaining training every three years.

The training matrix and individual staff records that we saw on the day of the inspection evidenced that there were a small number of gaps in the completion of mandatory training. We saw that staff had completed other training as well as mandatory training, such as dementia awareness, end of life care and food hygiene.

Although we did not ask to see evidence of staff supervision on the day of the inspection, staff told us that they attended regular supervision meetings with a senior member of staff and that they felt well supported. A member of staff said, "There is always someone to ask for advice."

A health care professional told us that staff carried out nutritional screening that included the Malnutrition Universal Screening Tool (MUST) and that they weighed people each month so they could identify any weight loss or gain. Two health care professionals told us that staff asked for advice and followed that advice appropriately.

The registered manager told us in the PIR document that there was a handover period at the beginning of each shift to ensure consistency in communication. Information about people's health and general well-being was recorded and passed to the staff who would be working the next shift to ensure that staff were always aware of each person's up to date care needs. Health care monitoring systems were in place such as input and output charts and regular weighing, and care plans included risk assessments and information about 'triggers' that might lead to people displaying certain behaviours. The registered manager told us that this helped staff to identify signs of ill health, pain or infection and medical attention or advice would be sought immediately.

People who lived at the home told us that they had good access to GP's, dentists and other health care professionals. One person told us, "If there is anything wrong they get in touch with my GP" and another said, "Just say to the lady in charge and she will get a Doctor." Staff told us that they would tell one of the senior care workers if someone needed to see a GP and they would arrange it.

Staff had recorded any contact people had with health care professionals; this included the date, the reason for the contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. For example, one person's health record stated, "Spoke to dietician over the phone to review (the person's) needs. They advised that we should carry on as we are." Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs. Visitors told us that they were kept informed of any changes to their relative's health and well-being.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs.

People were provided with equipment they needed to promote their health and well-being, such as equipment to aid their mobility, to promote good skin care and to aid continence.

People who lived at the home told us that staff knew what they liked to eat and whether they had special dietary needs. One person told us, "I don't eat a lot of meat and staff know I don't like it."

We asked staff how they found out about people's special dietary needs. They told us that this was through reading care plans. One member of staff said, "It's in the care plan, and on input / output charts."

Nutritional assessments and risk assessments had been carried out as well as swallowing assessments when this had been identified as an area of risk, and we saw that care plans included very specific information about people's special dietary needs. One person's care plan recorded that they required Stage 1 thickened fluids and needed to drink from a brown cup, as other cups flowed too fast and this increased the risk of choking. The care plan had been updated to record that the person needed Stage 2 thickened fluids and a pureed diet, and that they should be assisted to eat their meals with a teaspoon. Care plans included information leaflets about swallowing difficulties and about the texture of food and drink; this was designed to inform staff about good practice to avoid the risk of choking.

Good

Is the service effective?

We saw evidence in care plans that referrals had been made to dieticians and speech and language therapy (SALT) services appropriately. A health care professional told us that they had recommended enriched diets for some people and that staff "Were good at ensuring this happened." We saw one person's care plan recorded, "(Name) appetite has increased now and she is starting to gain weight. She has porridge in a morning with enriched milk and cream."

We observed that people who lived at the home were provided with hot and cold drinks throughout the day. In the afternoon people were offered fresh fruit as well as biscuits. We asked people if they were happy with the meals provided by the home. One person said, "Lovely – Sunday dinner roast was lovely. Breakfast – you can have what you want, tea-time sandwiches." However, one person told us that they would prefer to have tea at a later time; it was currently at 4.00 pm and they thought that was too early. We saw in the minutes of a staff meeting held in June 2015 that staff had discussed moving lunch to 1.00 pm and tea to 5.00 pm so it was clear that this was under discussion.

We observed the lunchtime experience. There was a menu board on display and this showed the main meal of the day plus other options that were available. One person had a different meal to the main meal on offer, and one person was offered a different dessert. One person was asked if they wished to remain in their wheelchair or transfer to a dining chair; this indicated that people were offered a choice of meal and a choice of where to sit to eat their meal. Some people used coloured plates and cutlery and this helped them to identify food on their plate so that they could eat independently. We saw one member of staff was standing when they assisted someone to eat their meal. They left to do another task and then returned to assist the person to eat their meal. However, they then stayed with the person until they finished their meal. We discussed this with the registered manager and they told us that it is the policy of the home for staff to remain with someone who they are assisting throughout the full meal, as a one to one approach is more likely to result in people eating their meal.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the Local Authority environmental health department. This inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service caring?

Our findings

Staff told us that they felt all staff who worked at the home genuinely cared about the people who they were supporting. One member of staff said, "We have a really good team here." We saw there was a 'family tree' placed in the entrance hall. Staff had written pledges about the care they promised to provide and these were hung on the tree.

People who lived at the home told us that staff cared about them and one person added, "Everybody seems to get on with everybody else." Both relatives who we spoke with told us they felt staff really cared about people who lived at the home. One relative said, "I really do, always smiling, I see them asking residents how they are."

We asked people if they thought the care centred around them and people responded positively. One person told us, "Yes, if I didn't I would not stay here." People also told us that staff communicated with them effectively. One person told us, "They talk to me when they get me ready" and another said, "They are busy but they do tell me."

Staff told us that they read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships and their likes and dislikes. They also told us they had time to spend with people; they said that key workers spend two to three hours a week with people, and that they made time to chat to people. We observed positive interactions between people who lived at the home and staff throughout the day.

Relatives told us that people were encouraged to do as much for themselves as they could, and this was supported by staff who we spoke with. We were told about one situation where a person had wanted to return to their own home. Staff had developed a programme of tasks to support the person to make drinks and a microwave meal; this was to help social care professionals assess the possibility of the person returning home. This evidenced that staff treated people as individuals and encouraged them to be as independent as possible.

The registered manager told us in the PIR document that bedroom door could be locked to promote privacy and dignity for people who lived at the home. People told us that staff respected their privacy and dignity and said that they always knocked on the door before entering; one person said, "Yes, they knock on the door and if I have company they don't bother me." Another person told us that their family and friends were made welcome at the home and they were able to see them privately in their own room. Staff were able to describe to us how they protected a person's privacy, such as giving them a towel to cover themselves with when they were providing assistance with personal care and asking people quietly if they needed help to go to the toilet.

At lunchtime we saw that two people used clothes protectors but other people were not offered them. We felt that, if people had spilt food on their clothes, this could have compromised their dignity.

Staff told us that, because they knew people well, they were able to recognise changes in their behaviour that indicated they were unwell, or were unhappy, even when they were not able to verbalise this. We saw staff assisting people in a caring and supportive manner so that they remained safe from harm. We noted that one person's care plan recorded, "(The person) wouldn't be able to say if they were in pain so observation of facial expressions is needed. Re-approach is often needed with (name)."

A health care professional told us that when they needed to discuss people who lived at the home with staff, they were always knowledgeable about their needs. The minutes of the staff meeting held in April 2015 recorded, "You have all been or will be given a client knowledge questionnaire. This is for you to test your own knowledge about the clients we provide personal cares for. We would like you all to complete one using the care files if necessary." This showed that the managers were being proactive in making sure staff understood people's individual care and support needs.

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

We saw that there were leaflets in the reception area of the home to inform visitors about available advocacy services and organisations that could provide useful information, such as Age Concern and the Alzheimer's society.

Good

Is the service responsive?

Our findings

The registered manager told us that they had an activity plan, although this was flexible depending on people's individual needs. However, baking always took place on a Wednesday so that the biscuits and cakes made were available for afternoon tea on a Thursday. The activity programme was available in written and in pictorial format.

Staff told us about the various activities that took place at the home, including dominoes, puzzles, hand massages, skittles, arts and crafts and gardening. They said they had time to encourage people to take part in activities, especially mid-morning and mid-afternoon.

We asked people what type of activities they took part in. Three of the four people who we spoke with told us that there were activities available, but they had chosen not to take part. One person told us they played dominoes, cards and hockey. They said, "There is always somebody doing something." We saw that the hairdresser was present on the day of our inspection and we were told they visited the home on Tuesdays and Thursdays. There was also a trip out on the afternoon of the inspection. Approximately eight people who lived at the home and a team of staff and helpers went in the home's mini-bus to a Boccia (a type of bowling) tournament that had been organised by the local authority. They all wore t-shirts that had Cassandra House printed on them; they returned whilst we were still at the home and were delighted that they had come second and said they were "Determined to come first next year."

At the time of the inspection staff were planning a 1940's / 1950's 'mock' wedding. People living at the home were invited to dress in outfits of the era and staff dressed as bride, groom and vicar. The local press printed an article about how successful the day had been in 'bringing back memories' for people who lived at the home.

The registered manager told us that they had recognised not many people were taking part in activities. They carried out a survey and one of the points identified was that people did not want to travel far to take part in external activities. A decision was made that they would only travel within 15 minutes of the care home, and the registered manager contacted a variety of venues within that radius, including the local golf club and garden centre. Because people enjoyed using the driving range at the golf club, the registered manager had asked the home's handyman to create some golf holes within the 'secret garden' at the home. Another suggestion in the survey was to have a fish tank in one of the lounges and we saw that one had been purchased.

Staff told us that they supported people to keep in touch with family and friends. People had access to telephones and were supported to use Skype so that they could contact relatives who lived away, including overseas.

The registered manager told us in the PIR they ensured that care plans were personalised and they produced an individual care plan that recorded who and what was important to the person concerned. Some people had this information recorded in a document called "This is Me." People who lived at the home told us that they had been involved in developing their care plans when they first moved into the home, but people were uncertain about whether their plan of care had been reviewed. However, we saw that care plans and risk assessments were reviewed each month. In addition to this, we saw that more formal reviews of care plans were carried out both in-house and by the local authority. When more formal reviews were held, people who lived at the home were invited to attend these meetings to discuss their care and support needs. One visitor told us that they had been involved in developing their relatives care plan and that they were aware that it had been updated after their relative had a fall at the home. This meant that staff had up to date information to follow about the people who they were supporting.

Staff told us that they always offered people choices. Comments from staff included, "We ask, we don't tell", "We ask whether they want to get up, where to eat meals, what drinks / food they want, if they want to join in activities" and "I ask them – what they want to wear, food choice options etc." People who lived at the home told us that they were involved in making decisions and choices. One person told us, "I am in control." We also asked people if staff obtained their consent before they provided assistance. One person said, "They ask if everything is OK" and another told us, "They would ask you."

We saw that the bathroom on the first floor was used as a store room rather than a bathroom. One person who lived at the home told us they would like to use this room but it was no longer available. Although there was a bathroom on the ground floor, we felt that this reduced the choice of bathing facilities available to people. We discussed this

Good

Is the service responsive?

with the registered manager on the day of the inspection and they told us this would be addressed; they had understood that people were happy with the bathing facilities available at the home.

We asked visitors to the home if they would know how to make a complaint. Both responded positively. One person said, "(The manager) said her door is always open – I feel confident to talk to anyone here but I have never needed to."

We checked the complaints log and saw that there were two complaints recorded for 2015; one had been from a relative about a person who lived at the home looking unkempt and another was about missing clothing. There was a full report of the investigation in the complaints log and this included details of a discussion that had been held with the safeguarding adult's team. An appropriate letter of apology had been sent to one relative. This indicated that staff were following the home's complaints policy and procedure. We saw that complaints and whistle blowing incidents were analysed to identify any improvements that needed to be made.

The complaints / comments / compliments log also included many thank you cards that had been received from relatives and these indicated that people had been satisfied with the care and support given to their relatives when they had lived at the home.

We saw that notice boards recorded information about activities, staff training, the complaints procedure and a notice to inform people that suggestions were welcome.

Good

Is the service well-led?

Our findings

A health care professional described the home as "A friendly place" and said they had no concerns about the care provided by staff. A visitor told us, "Whoever answers the door – they have a nice smile. I am relaxed about (name) being here."

The registered manager described the culture of the home. She said, "I continually tell staff that we are all cogs in a wheel." She said that all staff were involved in making decisions and this made them feel valued. Staff evolved with the home; the registered manager and deputy manager trained staff, worked alongside staff and had their breaks with staff. This led to an open culture where everything was discussed; staff were listened to and the registered manager acted on their ideas.

We asked staff what they felt about the management of the home and we received positive responses. One member of staff said, "I love it – it's like a big family. We all get on and always happy" and another said, "I think they are really good."

The registered manager told us in the PIR document that they had been successful in retaining staff; some had worked at the home for many years and we saw evidence to support this. The deputy manager had also been in post for a number of years, and either the registered manager or the deputy manager were on duty each day. This meant that people were supported by a team of staff who knew them well and who had been supporting them for a number of years, which enhanced the consistency of the service.

The registered manager told us in the PIR that they had an open door policy and that they held regular staff meetings, and staff confirmed that they attended meetings. They told us that night staff and day staff had regular meetings and that their views were listened to. The minutes of the staff meeting in April 2015 evidenced that staff had been given a client knowledge questionnaire, that person-centred care and the importance of hydration had been discussed and that staff had been asked to encourage people to join in activities and keep up with their interests. At the senior staff meeting in June 2015 the topics discussed included twelve hour shifts and it was decided that a full staff meeting would be held to obtain feedback. Other topics discussed included staff wearing pyjamas during the night to help people living with dementia to recognise that it was night time, medication, meal times, and the Care Certificate. This showed that staff were consulted about decisions that would affect their job role and the well-being of people who lived at the home.

We asked people who lived at the home if they were able to speak to the registered manager. Three of the four people told us they could. One person said, "She is approachable. I once asked her to change the carpet in my room and this was done" and another person told us, "She will sort a few things out and she comes and sees what you want."

The registered manager told us in the PIR that they held residents meetings and distributed questionnaires to ensure that people who lived at the home and their relatives had an opportunity to be involved in decision making about how the home was operated.

We asked people if they had been consulted about their satisfaction with the service they received. Only one person told us they were aware of meetings. They told us, "They have residents meetings but I don't go. I have done a food survey. (Name) is a very good cook" and another person told us, "Never been to a residents meeting and never done a survey." Visitors who we spoke with were not certain about meetings, but they had not been visiting the home for very long. However, we saw evidence that meetings and surveys were being used as part of quality monitoring at the home. There was a meeting in April 2015 and it was attended by nine people who lived at the home and eleven relatives. Topics discussed included postal votes, the fire procedure, CCTV monitoring and activities. The minutes recorded, "Everyone was asked individually if they had any comments or concerns. All complimented the staff, their commitment and the work they do." It was decided that they would start a relatives committee and six relatives or friends volunteered to be on the committee.

A survey on food provision had been carried out in May 2015 and we saw that the results had been collated and analysed. Following the survey, staff had been reminded that people must be made aware of alternative meals that were available at lunchtime; staff were given a list of suggested meals they could offer people. Staff told us that they thought people's views were listened to and confirmed that some changes were made to the menu following feedback received in the survey.

Good

Is the service well-led?

We reviewed the audit folder. This included an annual programme of audits and quality assurance monitoring tools. Some audits were carried out each month, such as medication, accident forms and care files. Other audits were carried out less frequently, such as training files. The folder also included details of any surveys that would be carried out during the year. In July 2015, for example, quality monitoring consisted of audits of medication, accident forms and care files, a visitor's questionnaire, a staff questionnaire and the checking of water temperatures. Some actions had been recorded following the staff survey; these included giving feedback to staff on the notice board and looking into the provision of books at the home and finding out more about large print and audio books. We saw that these actions had been completed.

A visitor's questionnaire had been carried out in July 2014 and was due to be carried out again. A new notice board had been placed in the entrance hall so that information could be displayed for visitors to the home; it was intended that the outcome of the visitor's survey would be displayed on the board.

We saw that any complaints made to the home, safeguarding issues that the home were aware of or accidents / incidents that had occurred were recorded in people's care plans. This indicated that managers were being open with staff and others about incidents that had occurred.

The minutes of meetings and staff supervision records evidenced that learning from any issues that had been identified or investigations that had been carried out were openly discussed, and improvements were made to the systems in place or staff practices to reduce the risk of incidents reoccurring. In addition to this, good practice guidance had been obtained from the CQC website and by the managers attending the Care Sector Forum (a meeting arranged for providers and managers by the local authority). This had been shared with staff so that current practices could be questioned and improved on. We were asked for advice on environments for people who were living with dementia and gave the registered manager details of some useful websites to access. This was followed up by the registered manager after this inspection.