Four Seasons (Bamford) Limited

Elm Bank Care Home

Inspection report

Dene Road
Hexham
Northumberland
NE46 1HW

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20 December 2016

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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

Summary of findings

Overall summary

We visited the home unannounced on 14, 19 and 20 December 2016.

We last inspected the service on 21 August 2015 where we found two breaches of Health and Social Care Act (Regulated Activities) Regulations 2014. These related to staffing and good governance. We also made four recommendations that best practice should be followed in relation to the management of medicines, the application of the Mental Capacity Act 2005 [MCA], the provision of a varied and balanced diet, and the décor and design of the service, particularly in relation to supporting people living with dementia. We asked the provider to take action to make improvements in these areas and this action has been completed.

Elm Bank Care Home provides accommodation and personal care for up to 43 older people, some of whom were living with dementia. Respite care and a day care service were also provided. The day care service is not regulated by Care Quality Commission (CQC) because it is out of scope of the regulations. There were 41 people using the service at the time of the inspection.

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

At the last inspection, we found that there were insufficient staff to meet the needs of people, particularly those living with dementia. We found that staffing levels had been increased and we observed that care was unhurried and people told us they were attended to promptly.

At the last inspection we found that governance arrangements in place had not identified all the shortfalls we found during our inspection. During this inspection we found that improvements had been made in all areas we had identified. There were improvements to the safety of the premises and equipment, and the home had been refurbished and redecorated, taking into account 'dementia friendly' design best practice. Feedback had been taken on board and acted upon.

Following our recommendation at the last inspection, we found that medicines were managed safely. Records were accurate and complete, and there were safe systems in place for the ordering, receipt, storage and administration of medicines. Quantities of medicines we checked were correct, meaning stock levels were accurate.

Risks to people and the environment had been assessed, and were regularly reviewed. We found that the staff and registered manager were not sufficiently aware of the status of a pressure ulcer of one person, who was being attended to by a district nurse. We made a recommendation that best practice should be followed in relation to the monitoring of skin integrity.

Staff had received training in the safeguarding of vulnerable adults and were aware of what to do in the event of concerns. Suitable recruitment practices were in place which supported safer recruitment decisions and helped to protect people from abuse.

The premises were clean and well maintained. Infection control procedures were followed by staff. Some unsuitable flip top bins we saw on the first day of the inspection, were replaced. There were no widespread malodours, and any issues with odours were addressed at the time they occurred.

Staff received regular training, supervision and appraisals. Recently introduced training in supporting people living with dementia had proven popular with staff who described to us the impact it had had on their approach, and the increase in empathy they felt towards people.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. it also ensures unlawful restrictions are not placed on people in care homes and hospitals.

The service was working within the principles of the MCA. Capacity assessments had been carried out and specific decisions taken in people's best interests were appropriately recorded. Applications to deprive people of their liberty had been made to the local authority in line with legal requirements. This had improved since the last inspection.

Following our recommendation regarding meals at the last inspection, new menus had been developed and all people we spoke with told us the food was good. People were consulted about additions to the menu and their satisfaction with meals was checked on a regular basis. Staff supported people well with eating and drinking. Where people had lost weight or had difficulties swallowing, appropriate professional advice was sought. Special diets were accommodated.

We observed that staff were very kind and attentive in their interactions with people. Relatives and visiting professionals told us staff were caring and we observed that people displayed warmth and humour towards staff with whom they clearly enjoyed good relationships. The privacy and dignity of people was maintained. Staff provided compassionate end of life care which was complimented by visiting professionals.

Care plans had improved since the last inspection. Following the introduction of a "dementia framework" these were more person centred and individualised. There was a greater emphasis on life story work to ensure care and activities could be tailored to meet individual interests and preferences.

The range of activities available had improved. We observed people enjoying group activities, and some people did individual activities such as painting. There were some concerns expressed, and we observed, that people who spent a lot of time in their rooms, or were unable to initiate contact with staff had fewer opportunities for engagement. We have made a recommendation about this.

A complaints procedure was in place. There had been no recent complaints and people were aware of how to complain if they needed to do so. Electronic surveys were available to all people, staff, and visitors to enable them to comment upon the quality and safety of the service. This provided real time feedback which could be responded to straight away by the manager. People were asked about their experience of the service on a regular basis.

The registered manager completed a number of quality and safety checks. We found an overall improvement in these since the last inspection. They had responded positively to the last inspection and had put a number of improvements in place. Staff and relatives told us the registered manager was helpful and approachable. There were systems in place within the wider organisation to monitor the quality and safety of the service.

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.

Staff and the registered manager were not always fully aware of tissue viability issues but steps were taken to immediately address this.

There were suitable numbers of staff on duty and people told us their needs were met in a timely manner.

There were safe procedures in place for the management of medicines. Staff competency to administer medicines safely was checked on a regular basis.

Individual risks to people were assessed. Care records of people prone to falls showed that risk assessments were up to date and appropriate plans were in place to try to prevent falls.

Risk assessments and safety checks had been carried out in relation to the building, premises and equipment.

Is the service effective?

Good

The service was effective.

Staff received regular training, supervision and appraisals and specialist training into the needs of people living with dementia had been provided.

Significant changes had been made to the environment in the unit for people living with dementia which supported their sensory, safety, social and recreational needs.

The service worked within the principles of the Mental Capacity Act 2005. Decisions made in people's best interests were appropriately recorded. Applications had been made to deprive people of their liberty in line with legal requirements.

People were supported with eating and drinking. New menus had been devised and satisfaction with meals was monitored regularly.

Is the service caring?

Good

The service was caring.

We observed staff to be kind caring and attentive during our inspection. We observed staff and people interacting with warmth and humour.

The privacy and dignity of people was preserved and staff were sensitive to the staff gender preferences of people to deliver personal care.

People were supported to maintain independence and staff sought their consent prior to carrying out care tasks.

Compassionate end of life care was provided and staff were complimented on this by health professionals.

Is the service responsive?

Good

Not all aspects of the service were responsive.

There had been an improvement in the range of activities offered including for people living with dementia, but people who spent time in their rooms, found it difficult to mix, or could not initiate contact with staff had fewer opportunities for engagement.

Improvements had been made to care plans, which were person centred and detailed.

A complaints procedure was in place. There had been no recent complaints and people were regularly consulted about their experience of care.

Is the service well-led?

Good

The service was well led.

Improvements made following the last inspection demonstrated that feedback had been taken on board and acted upon.

Audits and checks on the quality and safety of the service had improved. The deputy manager had supernumerary hours to enable them to concentrate on maintaining care records.

There were good links with the local community.

Elm Bank Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 14, 19 and 20 December 2016 and was unannounced. The inspection team consisted of one inspector.

Prior to the inspection we spoke with the local authority safeguarding and contracts teams and we took the information they gave us into account when planning our inspection. Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered 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 home including statutory notifications about deaths or serious injuries. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

During the inspection, we spoke with 14 people who used the service, five relatives, the registered manager, the deputy manager, the regional manager, five care staff, one domestic and a cook. We observed care and support being provided, and examined six care records and four staff recruitment files. We also examined a variety of records related to the quality and safety of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living in Elm Bank. One person told us, "I told my doctor how I felt about living here in a word, safe." Another person said, "I feel quite safe, no one could get in here." A relative told us, "We are very happy and confident with the care. We used to worry every night but we don't worry at all now."

At the last inspection we found a breach in Regulation 18. Staffing. Staffing levels did not always allow for a flexible and responsive service and the tool used to determine staffing levels did not take into account the needs of people living with dementia. Systems to monitor the quality and safety of the service were not sufficiently robust.

At this inspection we found there had been an increase in staffing numbers. We spoke with people about staffing levels and they told us there were enough staff on duty to meet their needs and there were no delays in being attended to. One person told us, "I just ring and they come straight away." One person told us they preferred to stay in their room and did not think there were enough staff to offer them one to one activities. We spoke with the registered manager and the regional manager about the comment made about one to one activities and they said they would look at staff deployment to ensure people had access to attention in their room if this was required.
We observed that staff responded to people in a relaxed unhurried manner, and we did not hear call alarms ringing excessively. We spoke with staff who told us that although it could be busy, they thought there were sufficient numbers of staff on duty. The only time there were difficulties was due to sudden sickness in which case replacement staff would be brought in as soon as possible. We spoke with the registered manager who told us that they could ask for additional staff in an emergency by contacting the regional manager if someone needed extra care for any reason.

We checked the management of medicines. At the last inspection we made a recommendation that the provider should follow best practice guidelines in relation to the management of medicines. At this inspection we found there had been an improvement in the management of medicines.
Safe procedures were in place for the ordering, receipt, storage, administration and disposal of medicines. Each day an audit of medicines for different people was carried out which included a check of medicine administration records [MARs], that all medicine was in stock, and whether any medicines had been omitted and the reason checked. We checked MARs and found there were no gaps. Handwritten entries on MARs were countersigned by two staff to ensure instructions were accurate. A running stock balance was recorded which meant stock was carefully monitored to ensure the correct amount of medicine had been given and there were adequate supplies. Controlled drugs [CDs] were stored securely and stock balances were checked by two staff each week and every time they were administered. A CD is a drug which is liable to misuse and therefore is subject to stricter control measures. We checked the stock balances of two CDs and found these were correct. Medicines delivered by a patch through the skin were managed appropriately and records included the location of the patch to ensure staff would know where to apply it should the patch fall off, or to enable them to rotate the site to avoid skin irritation. Fridge and room temperatures were recorded on a regular basis. There was a small number of gaps in these records and we spoke with the registered

manager who said they would remind staff to complete these daily.

At the last inspection we found that some furnishings and equipment were not in a satisfactory condition and one floor had a stale urine smell. At this inspection we found that the home had been redecorated and refurbished and was in a good state of repair. We were not aware of widespread malodour, and where an issue with odour had been identified, action was taken to address this. The premises were clean and tidy. Infection control procedures were followed and personal protective equipment was available including gloves and aprons. Some flip top bins were in place which should have been foot operated pedal bins to reduce the risk of the spread of infection. We spoke with the registered manager about this and they were replaced before the end of our inspection. We spoke with a member of domestic staff who told us they were aware of policies and procedures related to the control of infection. They described to us the procedure they would follow should there be an outbreak of infection in the building. They confirmed they had received training in health and safety and COSHH [control of substances hazardous to health]. We observed that cleaning materials which could be potentially hazardous were stored securely and were never left unattended by domestic staff during our inspection.

We checked the management of risks to people including risks associated with skin integrity such as the risk of developing pressure ulcers. Risk assessments were in place, which were updated on a regular basis. We found, however, that one person had a wound which staff described to us as a blood blister. This was covered by a dressing applied by a district nurse. Three staff were unable to tell us why this dressing was in place but felt it was a superficial wound. Care records showed that the wound was not superficial as described by staff, and was being monitored by the district nurse. We spoke with the registered manager about the monitoring of pressure ulcers and they told us they checked and reported on these on a regular basis but had not been aware that this wound was now a gradable pressure ulcer. They told us they would ensure that they were fully aware of the status of any wound being attended to by district nurses and that this information would be handed over to staff including any specific instructions. Twice weekly meetings were held with district nurses to improve communication and the registered manager told us she would discuss the status of wounds there.

We recommend that best practice is followed in relation to the monitoring of skin integrity.

Other individual risks to people had been assessed including related to the safe moving and handling of people and falls. Some people had fallen on a number of occasions. We checked the care records of people who were most at risk of falls and found that risk assessments had been carried out and reviewed on a regular basis. Paperwork was updated following a fall, and medical advice was sought where necessary. Preventative care plans and equipment such as pressure sensors to alert staff that people at risk of falling were moving, were in place. We spoke with a GP who visited the service regularly and asked them about falls management in the home. They told us they had no concerns with how staff managed falls and said they were contacted appropriately when there were concerns. One person had exhibited behaviour that placed them at risk and was being checked every fifteen minutes by staff to try to maintain their safety.

We reviewed staff recruitment files and found that suitable recruitment procedures had been followed. Appropriate checks were carried out including the provision of two references, and checks carried out by the Disclosure and Barring Service (DBS). The DBS checks that applicants are not barred from working with vulnerable people. This information helps employers to make safer recruitment decisions.

Staff told us, and records confirmed that they had received training in the safeguarding of vulnerable adults. One staff member told us, "I have done safeguarding training and if I suspected anything I would report it straight away." Staff were confident that they would recognise signs of abuse or neglect. There was one

safeguarding concern under investigation at the time of the inspection. We will report on the outcome if necessary once complete.

Safety checks of the premises and equipment were carried out. These included electrical, gas and legionella safety checks. Legionella checks are necessary to ensure that there is no risk of the bacteria being found in water systems used by people. Equipment used to move people such as wheelchairs and hoists were checked and serviced on a regular basis. Emergency contingency plans were in place and outlined what should happen in the event of a loss of facilities such as heating, or catering or in the case of flooding for example. It included emergency contact details and instructions for staff to follow. On call managers were available at all times to support staff in the case of an emergency.

Fire safety plans were in place and staff had received evacuation training. Equipment was tested regularly including alarms, firefighting equipment and emergency lighting. Personal emergency evacuation plans [PEEPS] were in place, these detailed the level of support people would need if they had to be evacuated from the service including their mobility needs.

Accidents and incidents were recorded. These were monitored by the registered manager who analysed them to check for any patterns or concerns.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received at Elm Bank. One person told us, "I feel well looked after, I think we are all okay here." A relative told us, "We are very happy with the care here. We can't fault a thing."

We checked menus and observed mealtimes. At the last inspection we found that menus were repetitive and did not offer a sufficiently varied diet. We made a recommendation about this. At this inspection the menus had been changed and the views of people and their relatives had been taken into account. Picture menus were displayed and we spoke with the cook who told us they asked people if they had enjoyed their meals on a regular basis. She also asked for feedback from staff serving meals and monitored the amount of food left over after meals. Special diets were catered for and diet notification sheets informed the kitchen staff of people at risk of losing weight or changes to their dietary needs. Attention was paid to the presentation of pureed meals which were piped to make them look more appetising. We asked about the quality of the food provided by the company and the cook expressed concerns about some of the food provided by their preferred supplier. They told us the executive chef was aware of concerns and was monitoring this and had asked for feedback. The cook told us they had most they needed but had put an order in for some new equipment. The registered manager told us that with the exception of one item which was no longer in use by the company, these would be supplied.

People were well supported to eat their meals. Tables were fully set with place mats, napkins, cutlery and condiments. We observed staff encouraging people to eat. One staff member said, "Try a bit of this, it's lovely, it's one of my favourite meals." They also tried to encourage someone to sit with other people in the dining room but respected their choice when they were reluctant to do so. They said, "Are you sure you don't want to come in here? That's fine, I'll bring your dinner to you." All of the people we asked said they liked the food. One person said, "The food is good and you choose every day. If you don't like something they will make something else." A relative told us, "The food is good, we have been here and seen the food; there's a good choice. They [staff] are always bringing cups of tea and there are nice cakes."

Nutritional risks were assessed. We found that where there were concerns about people including swallowing difficulties, or weight loss for example, referrals had been made to the appropriate professionals including speech and language therapists or dieticians. Weights were monitored and people more at risk were weighed on a weekly basis. Staff had received dysphagia training where they learned about difficulties with swallowing. They told us they had found this very helpful.

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 operating within the principles of the MCA. At the last inspection we found that capacity had not always been assessed in relation to specific decisions. During this inspection we found that applications to deprive people of their liberty had been submitted for authorisation to the local authority in line with legal requirements. We saw a list of these which included the expiry date and checklist to ensure CQC had been informed and the coroner where necessary. This meant the registered manager had introduced a system to ensure they met their legal obligations.

We found decisions made in people's best interests where they lacked capacity, were appropriately recorded. These included the decision for people to live permanently in the home, the use of lap belts on wheelchairs, sensor mats to prevent falls, and DNAR [Do Not Attempt Cardiopulmonary Resuscitation] orders. We were told that one person could be resistive to personal care due to their dementia related needs. As some care was essential for their health and dignity, a care plan to be followed in their best interests was in place. This decision was appropriately documented and interventions started with the least restrictive option. Multidisciplinary discussions had taken place around best interests decisions, and some relatives were consulted and were involved in the decision making process. Multidisciplinary discussions involve staff from the service, other care professionals including doctors or care managers, and family representatives. Where people had formal arrangements for someone to advocate on their behalf, such as a relative with lasting power of attorney [LPA], their legal status was not always clear in care documentation. We spoke with the registered manager about this who told us they would ensure they obtained evidence of this to include with care records. A LPA gives a nominated person legal authority to act on behalf of an individual.

Staff received regular training. One staff member told us, "We get a lot of training. My e learning [computer based training] is 100% up to date." We checked staff records and found training topics included infection control, moving and handling, safeguarding, MCA, DoLS, health and safety, basic life support and food safety, and pressure ulcer prevention. Staff told us and records confirmed they had received regular supervision and an annual appraisal. Staff supervision provides staff with the opportunity to meet with their line manager or supervisor on a regular basis to discuss their support and development needs. They told us they felt well supported. An induction process was in place for new staff who completed the Care Certificate. The Care Certificate is an identified set of standards that care workers adhere to in their daily working life.

At the last inspection we found that staff required further training to support people with dementia care needs. At this inspection we found that the provider had introduced a new dementia framework in the organisation and the service was in the process of achieving accreditation in this. This involved working in a way which provided maximum support to people living with dementia, and this also included the education of care staff. We spoke with staff who had received training which involved learning about the subjective experience of people living with dementia. They had worn special earphones, goggles, and gloves which allowed them to experience difficulties with their senses and dexterity which might be present in someone living with the condition. They were given a task to complete. One staff member told us, "It definitely makes you think and understand more what people are going through." Another staff member told us, "Training that makes you think is definitely worth doing. I wondered what I would get out of it but now I think about it all the time. I had to try and put a necklace on and I couldn't I felt frustrated and really annoyed. It makes you more aware of their [people's] experience."

A notice explaining about dementia was sensitively displayed just outside "Street Houses", the unit for people living with dementia, which visitors and staff could read. It contained information about different types of dementia and issues such as the importance of quality of life, nutrition and weight loss, and respecting the person living with dementia.

People had access to a range of health professionals. Records confirmed that people had access to GP's, district nurses, podiatrists, opticians. We spoke with a GP who told us, "The staff are caring and competent here."

At the last inspection we found that the environment did not support the needs of people living with dementia. Since the last inspection the premises had been refurbished and redecorated and attention had been paid to 'dementia friendly' design. This included improved signage and pictures to help orientate people to the purpose of the room including food related images in the dining areas. Handrails had been painted in contrasting colours to help people to identify these more easily.
Several areas of interest had been created on the 'Street Houses' floor which was the unit for people living with dementia. At the last inspection it had been referred to as the dementia unit so the new name was an improvement. A plastic greenhouse had been placed at the end of a corridor near a window, and a table with various plants and pots were available. There were garden chairs and walls were partially papered in brick wallpaper. This created a garden area for people to sit and explore plants and other gardening items. A corner area had a small picket fence with a washing line with baby clothes, and pegs. There were dolls and other items available. Other areas had a farming and library theme. There was also a bird aviary which one person in particular enjoyed sitting beside. Signs to encourage a sense of homeliness and belonging were displayed including one which said, "Take a seat, make yourself at home, relax and unwind, I'll put the kettle on, There's no place like home."

Good

Is the service caring?

Our findings

People, relatives, two GP's and a district nurse told us staff were caring. One person said, "I can't fault it. They are like my family and you are interested in all the other people here." Another person told us, "The staff are really good, I am waited on hand and foot." A relative told us, "Staff are lovely. They try really hard to keep everybody happy."

We observed staff interacting with people throughout the inspection. Staff spoke kindly to people and were attentive to their needs. They were observant and intervened if people looked as though they may need something. One staff member said, "Are you warm enough? It's a cold day today." A member of domestic staff saw one person appeared a little lost and said, "Do you know where your friend is? No? Then come with me." They reunited the person with their friend and they appeared more relaxed.

Staff were aware of equality and diversity issues and had received training. They were aware of people's individual needs wishes and beliefs. One person was supported to meet their religious needs by attending services. One person said he had a pain. A female member of staff asked if he would like her to take a look at it and he said no. She asked if he would prefer a male carer and he said yes. This meant that staff were sensitive about people's preferences regarding the gender of care staff.

We observed, and people told us, that staff treated them with dignity and respect. One person said, "They treat you with dignity and respect. They knock on the door and they are polite. Staff couldn't be any nicer." We asked staff about how they preserved dignity and they told us they knocked on doors and ensured people were not left exposed at any time during personal care. Records were held securely to maintain the confidentiality of information. We overheard one telephone call which should have been confidential. We spoke with the registered manager who told us they would remind all staff about this particularly when using a hands free telephone. We did not hear any other examples of this and observed staff were discreet and sensitive. Staff promoted independence and asked permission from people before they gave support with tasks.

People were bright and reactive and we observed staff and people laughing and joking together on a number of occasions. During one mealtime, three people sitting at a table had a fit of the giggles which went on for some time. Each time they stopped they would look at one another and it began again. One of the people said, "We can't even remember why we are laughing now. It's good for you though." There was also laughter when one person told us they had been doing memory games to stay sharp. A staff member commented "Don't you get any sharper!"

In addition to humour, staff displayed warmth and empathy towards people. Some people were very frail and we observed staff explaining what they were doing and gently encouraging them to eat and drink. One staff member said, "Please just have a little drink for me; just a little one. I've brought your favourite lemonade." Staff told us they enjoyed their work. One staff member told us, "I enjoy caring for older people, I love my job." Others told us they had been moved by the training about the experience of dementia.

End of life care was provided and staff had received training in how to support people as they neared the end of their lives. A district nurse told us that staff provided good end of life care. They said staff paid attention to detail and that people always looked comfortable and well cared for. Hospice staff could be contacted to sit with people at the end of their lives but the registered manager told us that this was something staff often chose to do in their own time as they were very caring.

No one was accessing any formal advocacy service at the time of our inspection but staff knew how to arrange this if necessary. An advocate acts on behalf of a person to impartially represent their views.

Good

Is the service responsive?

Our findings

People told us their needs were responded to. One person told us, "We are well looked after. It's like a first class hotel with benefits." Another person told us, "We have 24 hour care. We have buzzers if we need help and someone comes; in case you are wobbly. They come straight away." A third person told us, "I absolutely love it here we are spoiled in every way."

At the last inspection we were concerned that activities weren't always individualised and widely available. We made a recommendation about this. During this inspection we found that this had improved, and we observed a number of activities that were taking place during our visits. These included carol singing with local school children, hoopla, and decorating plant pots. One person told us, "She [activities coordinator] gives me plenty to do. It makes the time go much faster." Another person told us, "They bought me paints and I have started painting again. They get people in from outside to talk about the locality." Another person told us they had recently moved to the home and that they enjoyed the company; they said, "I came for a visit. I could go home if I didn't like it but I definitely want to stay here. At home I'd be all alone." One person told us they had enjoyed a cinema night where they had watched the film "Pretty Woman" and enjoyed crisps and lemonade. Activities in the Street Houses unit were provided to people living with dementia which reflected their preferences and previous interests.

Despite the improvement in activities available, a relative and visiting professional told us they did not feel that people had equal access to activities. We spoke with one person who told us they were bored but weren't good at mixing with others. They said they would appreciate meeting people with similar interests to themselves. We observed another person who spent a lot of time in their room. One two occasions we found them worrying about what was happening and had to ask staff to see if they were okay. They responded well to staff input and we were concerned that access to activities for people who wished to spend time in their rooms or were unable to initiate contact with staff was limited. We spoke with the registered manager and regional manager about this who said they would look in to this. They advised that they were rolling out the new care planning process in line with the dementia framework to all people as it provided a greater level of detail from which to plan social activities.

We recommend that activities are reviewed to ensure planning takes into account the needs of people requiring one to one attention from staff.

At the last inspection we found that information in care plans was not always detailed and personalised, particularly in the Street Houses unit. During this inspection, we found there had been an improvement in care plans following the introduction of the dementia framework. The care plans we read were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care.

A pre admission assessment was carried out before people moved into the home. This meant that the provider could ensure that they were able to meet people's needs. We saw that a care plan was written in preparation for people moving into the home which was monitored and reviewed over the first 48 hour

period to ensure it was relevant to the person's needs. More in depth plans were written following a longer period of assessment. The new dementia framework was a process carried out on an electronic device [IPad] which asked multiple questions about people's needs. The questions opened into additional areas depending upon responses of staff which meant that plans were individualised and tailored to the person's specific dementia related care needs. A greater emphasis had been placed upon life story and personal profiles which detailed what was important to people including relationships and lifestyle choices. Choices were also recorded in relation to whether people preferred a bath or a shower, or wearing trousers or skirts for example.

One senior care staff member was the lead for the dementia framework and told us about the work they had undertaken to educate and support staff. Staff told us they had found this very beneficial including learning more about how to support people exhibiting behavioural disturbance or distress. We observed staff supporting people appropriately and read entries in care records which described such episodes sensitively and respectfully. They used the term "distressed reactions" to describe what could be referred to as behaviour's that challenged. Records demonstrated a good understanding of behavioural issues in that they acknowledged these were usually the result of an internal trigger [thought] or external trigger such as the misinterpretation of the actions of another person for example. A GP we spoke with told us staff responded well to behavioural disturbance and they had involved the "challenging behaviour" team to help them to understand the reasons for the behaviours when necessary.

A complaints procedure was in place. People and relatives we spoke with told us they were aware of how to complain but had not had cause to do so. There had been no recent complaints and there was one on-going historical complaint. People, relatives and staff attended regular meetings where they could share their views about the service. An electronic system was available for people, relatives and visitors, including professionals, to share their views about the service including any concerns. This involved completing a survey on an electronic device [IPad]. This provided real time feedback, which enabled the provider to pick up and respond to any issues straight away. Staff also spoke with a sample of people each week to seek their views about the service. One person told us, "They [staff] ask us each week, did we have everything we needed, and is there anything we'd like. I suggested yoga for seated people so they are looking into that."

Good

Is the service well-led?

Our findings

At the last inspection, we found a breach of Regulation 17. Good Governance. This was due to the fact that routine audits and checks carried out by the registered manager had not identified shortfalls we found during our inspection. These related mainly to concerns about the quality of the experience of people living with dementia, the environment, and staffing.

During this inspection, we found that a number of changes had been made to improve the quality of the experience of people living with dementia. Staff had received training, the environment had been significantly enhanced and the dementia framework, led by an enthusiastic and passionate champion, had influenced a number of areas positively including person centred care planning and activities. Staffing levels had also increased. This demonstrated that feedback from the previous inspection had been taken on board and acted upon.

At the time of our inspection, there was a registered manager in place. Our records showed they had been registered with CQC since April 2012. They were supported by a deputy manager. People, relatives and staff told us the service was well-led and that the registered manager was friendly and approachable.

A number of audits and checks were carried out by the registered manager. These were carried out electronically using the company IPad "Tracas" to audit specific areas such as weight loss, medicines, health and safety and support for people living with dementia. Maintenance audits were also carried out. Reporting systems were in place which meant that important information about risks, people's care and treatment, accidents and incidents and safeguarding concerns, were reported to senior managers within the organisation. The deputy manager had been given some supernumerary hours to ensure care records were kept up to date.

In addition to this the registered manager regularly carried out observations on the quality of the service. A staff member told us, "The floors [units] run smoothly. The [registered] manager does daily walk arounds." Another staff member told us the registered manager was approachable and said, "I can talk to the manager if I have any issues." We saw records of manager spot checks around the home and noted she had checked that people appeared well presented and cared for, and that there was no clutter in the communal lounges for example. The registered manager was supported by a regional manager who visited the service on a regular basis and also carried out checks on the quality and safety of the service.

Daily "flash" meetings were held with heads of department so the registered manager was kept up to date with service wide issues. There were also regular clinical governance meetings. Clinical governance is a systematic approach to maintaining and improving the quality of care within a health or care system. There were also twice weekly meetings with district nurses to improve communication and to enhance joint working. Regular meetings were held with people who used the service and relatives.

Staff recognition schemes were in place, including national annual care awards run by the provider, and staff ROCK [recognition of care and kindness] awards. Staff also had access to childcare vouchers.

There were close links with the local community including churches and schools. The home had also taken part in a community gardening project and sought to maintain links with the community by inviting external speakers to the home.

The registered manager submitted statutory notifications to CQC in line with legal requirements. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.