Ringdane Limited

Dane House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 July 2016 and was unannounced.

Dane House provides accommodation for up to twenty-five older people, some of whom are living with dementia and who may need support with their personal care. On the day of our inspection there were nineteen people living at the home. The home is a large property, spread over two floors, with a communal lounge and a conservatory looking onto a large garden. It is situated in Brighton, East Sussex. Dane House belongs to the large corporate organisation called Four Seasons. Four Seasons provide nursing care all over England and have several nursing homes within the local area.

We carried out an unannounced comprehensive inspection on 13 and 14 March 2014. Breaches of legal requirements were found and following the inspection the provider wrote to us to say what they would do in relation to the concerns found. On 2nd March 2015 we carried out a focused inspection to check that they had followed their plan and to confirm that they were meeting legal requirements. At that inspection we found that significant improvements had been made, however, we continued to have concerns with the recording of mental capacity assessments, staff's understanding of Deprivation of Liberty Safeguards (DoLS), the opportunity for meaningful activities for people and involving people in the running of the home. At the inspection on 12 July 2016 we found that significant improvements had been made, however, we continue to have concerns regarding the lack of staff training, knowledge and understanding in relation to the Mental Capacity Act 2005 (MCA) and DoLS. Further areas in need of improvement related to people's dining experience and end of life care.

People's consent was gained before staff offered support. One relative told us "They always inform me and ask my consent if needed". There were good systems in place to assess people's mental capacity and ensure that any decisions made on their behalf were made in their best interests and with people that were legally able to make decisions. However, there were concerns regarding staff's training, knowledge and understanding in relation to MCA and DoLS and we have identified this as an area of practice in need of further improvement.

People told us that they were happy with the food and that they were able to choose what they had to eat and drink. Observations showed people being appropriately supported by patient and sensitive staff. However, people's dining experience was poor. Most people ate their meals in their rooms, whereas others were in the communal lounge. People ate their meals on lap tables in the arm chairs that they had spent most of the day in, this didn't aid their independence or enable them to orientate to time and place and know that it was time for lunch. The registered manager recognised that this needed to improve and told us that there were plans to redecorate the conservatory area to create a 'fine dining' experience for people. This is an area in need of improvement.

One person was receiving end of life care, they were treated with compassion and kindness by staff and their health and physical needs were met. However, there was a lack of holistic care and the person spent their

time in bed with minimal stimulation or possessions near to them. People were not asked their preferences in regards to how they wanted to be supported at the end of their lives. The registered manager recognised that this was an area that needed further improvement, they had already made contact with the local hospice and planned to implement advanced care plans for people.

The management team consisted of a registered manager and a deputy manager. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home was well-led and managed well. People, relatives and staff were complimentary about the leadership and management of the home and of the approachable nature of the registered manager. One person told us "I can talk to the manager, in the past there was a rapid turnover of staff but this has all changed". Another person told us "The deputy manager is excellent, they are keen and enthusiastic and will talk to you anytime". There were quality assurance processes in place to ensure that the systems and processes within the home were effective and ensured that people's needs were being met and people were receiving the quality of service they had a right to expect.

People's safety was maintained as they were cared for by staff that had undertaken training in safeguarding adults at risk and who knew what to do if they had any concerns over people's safety. Risk assessments ensured that risks were managed and people were able to maintain their independence. There were safe systems in place for the storage, administration and disposal of medicines. People told us that they received their medicines on time and records and our observations confirmed this.

Sufficient numbers of staff ensured that people felt safe and their needs were met. One person told us "I can ring my bell for help so that's how I feel safe". There were suitably qualified, skilled and experienced staff to ensure that they understood people's needs and conditions. Essential training, as well as additional training to meet people's specific needs, had been undertaken and used to improve the care people received. People and relatives told us that they felt comfortable with the support provided by staff. One relative told us "I think some are excellent". A visitor told us "They must be well trained because they can deal with any occurrence".

People's healthcare needs were met. People were able to have access to healthcare professionals and medicines when they were unwell and relevant referrals had been made to ensure people received appropriate support from external healthcare services.

Positive relationships between people and staff had been developed. There was a friendly and homely atmosphere and people were encouraged to maintain relationships with family and friends who were also able to visit the home. People were complimentary about the caring nature of staff, one person told us "They always have time for a chat and will do anything you ask, I can't fault them at all".

People's privacy and dignity was respected and their right to confidentiality was maintained. People were involved in their care and decisions that related to this. Residents' meetings enabled people to make their thoughts and suggestions known. People's right to make a complaint was also acknowledged. The registered manager welcomed feedback and used this as opportunity to develop the service provided. People received personalised and individualised care that was tailored to their needs and preferences. Person-centred care plans informed staff of people's preferences, needs and abilities and ensured that each person was treated as an individual.

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 home was safe.

People received their medicines on time, these were dispensed by registered nurses and there were safe systems in place for the storing and disposal of medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks and maintain their independence.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and had worked in accordance with this. However, staff lacked knowledge and understanding in relation to this.

People were happy with the food provided and were able to choose what they had to eat and drink. However, the environment in which people could eat their meals was not conducive to a positive or social dining experience.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Is the service caring?

Requires Improvement

The home was not consistently caring.

There was a lack of holistic care for people who were at the end of their life. There were a lack of systems in place to enable people to make their wishes known in relation to end of life care.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. Staff appeared to know people well.

People were involved in decisions that affected their lives and their care and support needs. People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Good

The home was responsive.

Care was personalised and tailored to people's individual needs and preferences.

People had access to a range of activities to meet their individual needs and interests.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals' and their opinions and wishes were taken into consideration in relation to the running of the home.

Dane House 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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 12 July 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor 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 home was last inspected in March 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to the maintenance of accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The home received an overall rating of 'Requires Improvement' after our inspection on 2 March 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

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Prior to the inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to the inspection included previous inspection reports, the local authorities' commissioner's report and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eight people, two relatives, nine members of staff, two visiting healthcare professionals, the registered manager and the regional manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for eight people, medicine administration records (MAR), five staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounge and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

Good

Is the service safe?

Our findings

People and relatives told us that the home was a safe place to live, that there were enough staff to meet people's care and support needs and that people received support promptly. Observations demonstrated that people felt at ease in the presence of staff. When asked why they felt safe, one person told us "I can ring my bell for help so that's how I feel safe".

People were cared for by staff that the registered manager had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed, and their employment history gained. In addition to this their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers' make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses all had current registrations with the Nursing and Midwifery Council (NMC).

Sufficient numbers of staff ensured that people were safe and well cared for. The registered manager used a dependency tool to assess the required staffing levels to meet people's needs. Each month people's individual care and support needs were assessed and this was used to inform the staffing levels, which could be adapted if people's needs changed. People, relatives and staff told us that there were sufficient staff and that when people required assistance staff responded in a timely manner, our observations confirmed this. One relative told us "I think there are enough staff on duty to make them feel safe".

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy enables staff to raise concerns about a wrongdoing in their workplace.

People's freedom was not restricted and they were able to take risks. People's needs had been assessed and risk assessments were devised and implemented to ensure their safety. For example, care plan records and risk assessments for one person, who smoked, showed that the registered manager had considered the risks to the person as well as other people. An agreement between the registered manager and the person had been incorporated into the person's risk assessment and it was agreed that the person would go into the garden to smoke. The person told us "I feel safe, I am able to go out into the garden for a smoke with my Zimmer frame".

Accidents and incidents that had occurred were recorded and analysed to identify the cause of the incident and determine if any further action was needed to minimise the risk of the incident occurring again. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan.

People and relatives told us that they were happy with the support people received. People were assisted to take their medicines by registered nurses. People's consent was gained and they were supported to take their medicine in their preferred way. People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Some people were supported to have their medicines covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example hidden in their food or drink. There were safe and appropriate protocols in place for the safe administration of covert medicines.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 2 March 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns regarding insufficient guidance in people's care plans in relation to how people that were subject to a Deprivation of Liberty Safeguard (DoLS), should be supported effectively. After the inspection, the provider informed us of what they would do to meet the legal requirements in relation to this regulation. Improvements had been made in relation to the detail and guidance in relation to DoLS in people's care plans and the provider was meeting the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found areas of practice, in relation to the Mental Capacity Act 2005 (MCA) and DoLS that required further improvement.

The 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 DoLS.

We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Nine people had a DoLS authorisation in place. Some people had conditions applied to their DoLS authorisations and the registered manager had ensured that these were actioned. For example, the DoLS condition for one person stated that there needed to be clear, documented evidence in the person's care plan in relation to medicines that were administered covertly. Observations of the person's care records confirmed that this was the case. Staff asked people and gained their consent before offering any assistance. One relative, who had legal authority to make decisions on their relative's behalf, told us "They always keep me informed and ask my consent if needed". Records showed that a majority of staff had completed MCA and DoLS training. However, discussions with staff showed them to have a minimal understanding of the implications of MCA and DoLS. This raised concerns regarding staff's ability to support people in a way that promoted their rights and did not restrict their liberty. Therefore this is an area of practice in need of improvement.

People told us that they enjoyed the food and had a choice of menu each day. One person told us "I love the food". Most people chose to have their meals on trays and lap tables in their own rooms. Five people were in the lounge, three of whom were having their meals sitting in the armchairs that they had spent most of the day in, this didn't help people to orientate and know that it was time for their meal, nor did it aid their digestion or independent eating. People received appropriate assistance to eat and drink and staff demonstrated patience and understanding when assisting people, ensuring that they were ready for the support provided and were enjoying their meals. There was soft music playing in the background, creating a relaxed atmosphere. However, the environment was not conducive to a social meal time experience as people were not able to communicate with one another as they were sitting in separate arm chairs or in

their own rooms. The registered manager recognised that the dining experience for people needed to improve and informed us of their plans to create a 'fine dining' experience for people by redecorating the conservatory area. This is an area of practice in need of improvement.

People told us that they felt that staff had appropriate and relevant skills to meet their needs. One person told us "I think some are excellent". A visitor told us "They must be well trained because they can deal with any occurrence". The registered manager ensured that there was a commitment to learning and development from the outset and told us that they had plans to improve this even further. Staff that were new to the home were supported to undertake an induction which consisted of familiarising themselves with the provider's policies and procedures and orientation of the home, as well as an awareness of the expectations of their role. The registered manager explained that new staff would also be supported to work towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers.

Staff had completed most essential training and this was updated regularly. In addition they had undertaken training that was specific to the needs of people. For example, dementia awareness. Registered nurses ensured that their practice was current, they undertook relevant training courses and were registered with the Nursing and Midwifery Council (NMC). Although sufficient, both the registered manager and staff felt that the training for staff could improve. The majority of training was undertaken through e-learning programmes. E-learning is self-directed electronic learning. One member of staff told us "I don't think e-learning is sufficient and I would like to attend more face to face training or for this to be offered". The registered manager told us about their plans to improve the quality of training offered, she told us that the management team had plans to introduce more practical-based training.

There were links with external organisations to provide additional learning and development for staff, such as the dementia in-reach team. The dementia in-reach team provides advice, training and information for care homes that provide care to people living with dementia. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. Some staff were working towards diplomas in health and social care. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions and appraisals helpful and supportive, however, explained that they could also approach the registered manager at any time if they had any questions or concerns. One member of staff told us "She is a very supportive manager and I can go to the manager with any issues or concerns".

People's communication needs were assessed and met. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. For example, when supporting a person who had impaired sight, the member of staff approached the person and introduced themselves whilst using gentle touch to alert them of their presence. They noticed that the person's hands felt cold and asked them if they would like a blanket. The person did and when the member of staff assisted the person they explained what colour the blanket was and encouraged the person to touch and feel the material. Communication between staff was also effective. Regular handover and team meetings, as well as a written communication book, ensured that staff were provided with up to date information to enable them to carry out their roles.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians, physiotherapists, speech and language therapists

(SALT) and tissue viability nurses (TVN). Healthcare professionals told us that the home responded promptly to people's health needs. Staff told us that they knew people well and were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. People and relatives' confirmed this and one visitor told us "My friend was taken to hospital during the night. The staff rang me and I followed the paramedics".

People's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool and a Malnutrition Universal Screening Tool (MUST), these took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had pressure wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended, photographs of wounds had been taken to monitor their improvement or deterioration. For one person these photographs showed a significant improvement in the condition of their skin due to the treatment and wound management carried out by staff. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, these people were weighed each month, unless it was detrimental to their well-being, to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP and SALT. Advice and guidance provided by the GP and SALT had been followed, for example for one person who was at risk of malnutrition it had been advised that the person had fortified drinks, observations confirmed that these had been provided.

Requires Improvement

Is the service caring?

Our findings

There was a friendly, homely atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that they were well cared for. One person told us "They always have time for a chat and will do anything you ask, I can't fault them at all". Results from a healthcare professional survey contained comments such as 'It's very warm, welcoming, full of smiles and good care". However, despite these positive comments we found an area of practice in need of improvement.

Registered nurses had received end of life care training from a local hospice and shared their knowledge with other members of staff. People were able to remain at the home and were supported until the end of their life. According to the Social Care Institute for Excellence (SCIE) people with dementia should be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advise that providers' of homes also need to ensure that they are prepared for situations and do their best to ensure that they know, document and meet the person's wishes at the end of their life. Observations showed one person was receiving end of life care. The person was cared for by staff to ensure that they were comfortable and had access to food and drink. However, there were no plans in place that specified the person's wishes with regard to how they were cared for at the end of their life, nor was there any information for staff to follow in relation to the person's religious wishes. Subsequent to the inspection the registered manager informed us that there were comprehensive end of life care plans in place for this person, however, these were not made available to us at the time of the inspection. The lack of advanced care plans was discussed with the registered manager at the time of the inspection, they told us that these were usually devised when people were nearing the end of their lives. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time. When this was raised with the registered manager she explained that this was something that needed to be addressed with people but explained that if people had a DNACPR (Do not attempt cardio-pulmonary resuscitation) in place, then this would be discussed sooner. The lack of advanced care plans was an area of practice that required improvement.

Observations of staff's interactions showed them to be kind and caring. One person was supported by a member of staff to have a drink. They offered verbal explanations to the person, such as "I've got a lovely warm cup of tea here", "Are you ready"? "Is it nice"? Another member of staff was observed assisting a person who had fallen asleep in their armchair. The member of staff had noticed that the person looked uncomfortable and supported them to position a cushion to ensure their comfort. Another person kept asking for their father, a member of staff noticed that the person was showing signs of apparent anxiety and sat alongside the person and reassured them, asking "Your husband is visiting today isn't he? What days does he usually visit, you're devoted to one another aren't you"? The person appeared to enjoy talking to the member of staff and began smiling and after the interaction was left looking reassured and calm.

People were treated with respect and were able to independently choose how they spent their time. They were cared for by staff that knew them and their needs well. People were encouraged to maintain

relationships with their family and friends and received visits throughout the day. People appeared to enjoy interacting with staff and it was apparent that caring relationships had been developed. People's privacy was respected. Information held about people was kept confidential, records were stored in locked cabinets and offices to ensure confidentiality was maintained. Staff showed a good understanding of the importance of privacy and dignity and how this should be maintained. People confirmed that they felt that staff respected their privacy and dignity. Observations of staff interacting with people showed that people were treated with dignity and respect. For example, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

People were involved in their care. Records showed that people and their relatives had been asked people's preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt fully involved in the delivery of care and could approach staff if they had any questions or queries relating to it. Observations showed that relatives were involved in their loved ones care. They were observed talking with staff about the care their relative had received. Resident and relative's meetings provided people with an opportunity to be kept informed and to raise any concerns or suggestions that they might have. Staff told us that people used these meetings to make their thoughts known and records confirmed this. Records of a recent resident's meeting showed that people had been consulted about the redecoration of the communal areas. Observations further confirmed that people were asked their opinions and wishes and staff respected people's right to make decisions. Most staff explained their actions before offering care and support and people felt that staff treated them with respect and that they took time to talk, explain information and listen to their needs. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Good

Is the service responsive?

Our findings

At the two previous inspections on 13 and 14 November 2014 and 2 March 2015, there were concerns regarding the lack of activities and opportunities for social engagement for people. Improvements had been made in relation to the provision of activities and there were further plans for its continued development.

The registered manager had recently employed an activities coordinator. On the day of our inspection there were two activities coordinators as the activities coordinator from one of the provider's other care homes was inducting and assisting the new member of staff. The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people and taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Records showed that people had been entertained by external entertainers such as jazz singers, soprano singers, harpists. They had received visits from guide dogs and had taken part in art classes and had talks from guest speakers about animals. People, relatives and staff told us how much people had enjoyed this. One relative told us "My relative goes to the lounge, but I'm not sure she responds, last week they had a sing song and she became emotional so it must have made an impression". It was apparent that there were plans in place to further improve the activities and social engagement for people.

Observations showed a minimal amount of people spending time in the communal lounge. A majority of people preferred to spend time in their own rooms, undertaking activities of their choice, such as reading or watching television and staff respected people's rights to choose how they spent their time. People told us that they were happy and that staff did spend time with them so that they weren't isolated, our observations confirmed this. One person told us "I don't want to leave my room, I don't want to take part in activities". People in the communal areas were supported to listen to music of their choice and observations indicated that they enjoyed this as they were observed tapping their feet to the music. The registered manager had recently adopted two cats for the home and it was apparent that people enjoyed watching the cats and coaxing them with treats. Observations showed two people calling the cats and interacting with them. A member of staff was overheard saying "I told you they would come to you X", the person was then overheard saying "I love them". Staff told us about a person who had previously chosen not to leave their room and who had limited conversation with anyone, they explained that since the cats had been at the home the person had been coming out of their room and was now communicating with people.

At the previous inspection on 2 March 2015, there were concerns regarding the lack of information in people's care plans in relation to their personal life histories and what was important to them. Improvements had been made, some people's care plans contained information about their lives before they moved into the home. One person's care plan contained information and photographs about the person's family tree, their previous employment, holidays they had enjoyed and their love of cats. Observations showed that staff used this information when supporting the person, for example, the person and staff were watching the cats play, which they clearly enjoyed as they were observed smiling.

People and relatives told us that they were fully involved in decisions that affected people's care. People's physical and health needs were met. People's needs had been assessed when they first moved into the

home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed that they had been involved in the development of the care plans. People and relatives had given their consent for their care plans to be reviewed on a monthly basis by the care staff, unless changes occurred before this time. There were regular reviews that took into consideration changes in people's needs and care was adapted accordingly.

People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what time they wanted to get up, what clothes they wanted to wear, what pass time they wanted to do, what they had to eat and drink and what they needed support with. People were also able to choose if they received support from male or female carers. People were happy with their rooms and were able to furnish them according to their tastes and display their own ornaments and photographs.

There was a complaints policy in place, there had been no complaints made since the previous inspection. The registered manager encouraged feedback from people and their relatives. There were suggestion boxes for people and relatives to use and leaflets provided information as to how they could make comments about the home on external websites and with external parties. There were also electronic feedback systems to enable people, visitors and healthcare professionals to offer feedback. People and relatives told us that they didn't feel the need to complain but would be happy to discuss anything with the manager, who was always approachable and listened to their concerns or suggestions.

Good

Is the service well-led?

Our findings

At the previous inspection on 2 March 2015, there were concerns related to the lack of a registered manager being in post as well as the lack of systems in place to obtain the views of people. Improvements had been made. There was a registered manager in post who had worked in the home for six months. People, relatives and staff were complimentary about the improvements that had been made since they had been in post. They told us that they were encouraged to make their feelings known, that the registered manager was friendly, approachable and listened to and acted upon their comments and suggestions. One person told us "I can talk to the manager, in the past there was a rapid turnover of staff but this has all changed". Another person told us "The deputy manager is excellent, they are keen and enthusiastic and will talk to you anytime".

Dane House is part of a large, corporate organisation called Four Seasons. Four Seasons provide nursing care all over England and have several nursing homes within the local area. The management team consisted of a registered manager and a deputy manager. The provider had a philosophy of care that stated 'We are committed to providing the highest possible standards of care. Residents will be treated as individuals and cared for with respect and dignity within a safe, comfortable and homely environment which provides stimulation and encourages independence where appropriate'. This was embedded in the culture and implemented in practice. There was a friendly, homely atmosphere. The registered manager promoted their own philosophy amongst the staff team, explaining that 'we work in their home' and told us "I don't want the home to feel clinical, I want it to be a homely home".

Feedback from people, relatives and staff, as well as our observations, showed that there was good leadership and that the home was well-managed. Staff were complimentary about the leadership of the home and told us that the home felt more settled now that there was a manager in post. One member of staff told us "You can raise issues with the manager, if something happened she would help, there is an open culture. It's good here, very friendly. We have meetings and supervisions and in the staff room there is a suggestions board which is brought to the meetings". Another member of staff told us "We are supported 100% by the manager. It is amazing how we work here, morale is high". Observations confirmed that staff's feedback had been listened to and acted upon. Records of a recent staff meeting showed that staff had asked for a cook to be available at supper times. Observations and discussions with the cook confirmed that this had been implemented as the cook worked longer hours to ensure that they were there for supper time. Records within the staff communication book provided further evidence of the registered manager's leadership style, it stated 'To all team members involved with the activities, well-done! Dane House felt like a home and everyone worked together as a team'.

There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting people's needs. There were mechanisms in place to obtain feedback from people, relatives', visitors', staff and visiting professionals'. As part of the registered manager's quality monitoring a facility known as 'Quality of life' was available for people to provide regular feedback by registering their feedback on an I-pad. The feedback was monitored by the registered manager and regional manager to ensure that any concerns were addressed and action taken in response. In

addition to this, resident and relative meetings were held to enable people to share their thoughts and concerns. Quality assurance audits conducted by the registered manager and regional manager provided an oversight and awareness of systems and processes. This ensured that people were receiving the quality of service they had a right to expect. The registered manager had used learning from other homes within the local area to improve the systems that were in place within the home. For example, following an incident in relation to medicines management in another home the registered manager had ensured that all registered nurses had their competence reassessed when administering medicines to people.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, the dementia in-reach team, local hospices and private training providers. The registered manager worked closely with external health care professionals such as the GP and district nurses as well as attending manager forums to ensure that people's needs were met and that the staff team were following best practice guidance.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.