Country Court Care Homes Limited

Belmont House

Inspection report

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Ratings

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

Overall summary

Belmont House is a care home which is registered to provide accommodation and personal care for up to 52 people, who may have nursing needs or be living with dementia. On the day of our inspection there were 46 people living in the home.

There was a manager at the service who was registered with CQC. 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.

We last inspected Belmont House on 21 May 2013 and found that the service was meeting the requirements of the regulations we reviewed at that time.

The registered manager understood Deprivation of Liberty Safeguards (DoLS) and applied for authorisations as needed which we saw evidence of. The registered manager was in the process of making further

Summary of findings

applications. However, we found that the arrangements in place for obtaining consent for decisions did not always follow the principles of the Mental Capacity Act 2005 (MCA). For example, one

person was administered medicines covertly. Although the person's GP had been consulted and deemed this to be safe, there was no evidence that a best interest meeting had taken place to demonstrate that decisions were being made in line with their best interests.

During our inspection we observed the number of staff on duty relative to people's needs and looked at how quickly people were able to summon assistance. We saw that there were enough staff to keep people safe but that staff often did not have time to spend talking with or comforting people because they were so busy. For instance, a person who was anxious and shouting out was attended to by kind and understanding care staff but they could not spend time sitting with the person because there were too few of them to do this alongside their other duties. One person who used the service told us, "They could really do with more staff. Sometimes they are short staffed and it makes it really hard for staff. They can't be everywhere." Another person said, "The staff are excellent. I feel very safe here."

The home was clean and tidy, however there was an unpleasant odour along the corridors in both the residential and nursing units. At times there was an overwhelming smell of air freshener or something similar which was intended to mask the odours but in fact made it worse. There had been some refurbishment in areas of the home but a number of areas were looking very tired.

Some people who used the service had been identified as being at risk from low nutrition. Their care plans stated that they must have their food and fluid intake recorded. We saw that on some days the food and fluid charts had not been fully completed. This meant people who used the service were not protected from the risk of inadequate nutrition and hydration. During the inspection we did not see any snacks and fresh fruit available. When the tea trolley was brought round in the morning and afternoon there was no offer of anything other than a drink. One member of staff told us people could have snacks whenever they wanted and we asked how people would know this but they were unable to tell us.

Prior to the inspection we contacted 11 healthcare professionals to ask them their opinions of the service. They all gave us positive feedback about the service. They told us people who used the service were well cared for by staff that were well trained and professional. Healthcare professionals told us they did not have any concerns regarding the care and support provided to people. One healthcare professional told us, "The staff are friendly and we have a good working relationship with them."

From discussions with staff we found they were fully aware of how to raise any safeguarding issues and were confident the senior staff in the service would listen. One person said, "'The staff are excellent. I feel very safe here."

We found the service had appropriate arrangements in place to manage medicines so people were protected from the risks associated with medicines.

The service employed an activities co-ordinator and we saw some activities take place. However, there were periods of time where there was a lack of stimulation for people.

Staff said the training they completed provided them with the skills and knowledge they needed to do their jobs. Care staff understood their role and what was expected of them. They were happy in their work, motivated and confident in the way the service was managed.

Staff said that communication in the home was good and they always felt able to make suggestions. There were meetings held for all staff every two months and additional meetings for groups of staff, for example, senior care workers and ancillary staff. Minutes of these meetings showed this was an opportunity to share ideas and make suggestions as well as being a forum to give information.

The service had a complaints policy and procedure. People and relatives told us they could talk with staff and managers if they had any complaints or concerns. One person said, "If I wasn't happy about anything, I would tell the senior and if she didn't sort it out, I would tell [the manager]. She [the manager] is very approachable and looks after everybody here."

During our inspection, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Staffing levels were regularly assessed, but we saw some periods of time where there was a lack of staff presence in communal areas.

Some areas of the home needed updating and there was an unpleasant odour which was unappealing and also posed a risk to effective infection control.

Appropriate arrangements were in place for the safe administration of medicines.

There were effective recruitment and selection procedures in place.

Requires improvement

Is the service effective?
The service was not always effective.

Where it was stated that people lacked capacity for specific decisions, best interest meetings had not always taken place.

The food and drink intake of people who were at risk of poor nutrition was not always monitored so that action could be taken as necessary.

Staff received regular supervision and appraisals. Training was monitored to

ensure staff had relevant skills and knowledge to support people they cared for.

Inadequate

Is the service caring?
The service was caring.

We saw that staff respected people's privacy and dignity and knew people's preferences well.

Staff were caring in their approach and interactions with people. They assisted people with patience and offered prompting and encouragement where required.

Good

Is the service responsive?
The service was responsive.

People and relatives told us they felt confident to raise any issues with staff and managers.

The service employed an activities co-ordinator, however, there were periods of time where there was a lack of stimulation available for people.

Good

Is the service well-led?
The service was well led.

Requires improvement

Summary of findings

There was an experienced registered manager in post who was approachable and communicated well with people who used the service, staff and outside professionals.

There was a quality assurance system in place which identified and acted upon areas for improvement and highlighted good practice.

Belmont 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 March 2015 and was unannounced. Two adult social care inspectors and an expert by experience carried out the inspection. 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 had experience in caring for older people and people living with dementia.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

We also contacted commissioners of the service and received feedback from two GP's, three specialist nurses and Sheffield local authority contracting and commissioning team. This information was reviewed and used to assist with our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. 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.

During the visit, we spoke with 15 people who used the service, five relatives, the registered manager and seven members of staff, including a nurse, care workers and ancillary staff. We also spent time looking at records, which included four people's care records, seven staff personnel records and records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

Two people who lived at the home told us they thought there were not enough staff to deal with everyone's needs. One person said, "They could really do with more staff. Sometimes they are short staffed and it makes it really hard for staff. They can't be everywhere." Another person said, "They could definitely do with another pair of hands."

Two relatives told us they thought there were not enough staff at times to deal with the needs of their family member. One relative said, "There are not enough staff. It all falls apart when somebody is off sick."

There were 46 people living at the home. On the day of our inspection there was one qualified nurse, one senior care worker and seven care workers on duty. There was also an administrator and ancillary staff working in the laundry, kitchen and throughout the home. This met the number of staff that had been assessed as required by the registered manager when taking into consideration the dependency needs of people who lived at the home.

Throughout our inspection we observed staff were very busy providing personal care to people. This meant there was not much time for staff to spend quality time socialising and conversing with people who used the service. This also meant we saw people did have to wait for assistance during busy times, for example, during mealtimes.

During our SOFI observation we spent time in the main dining room. There were periods of time (up to five minutes) when there was no staff in the dining room to assist people with their breakfast. We saw people sat at tables waiting for their breakfast to be served for over 15 minutes. Staff were busy getting people up and into the dining room. When people were supported into the dining room the care workers gave them a drink and cereal and then left the dining room to go and get other people up. People were then left waiting to be served their toast or to be given assistance with eating their meal.

We also spent time in the lounge in the nursing unit. At one point in the day there were no staff in the lounge area for half an hour. We saw one person was sitting on top of another person in one chair. The person in the chair was crying and shouting, "She's hurting me." One staff member came and tried to move the person who was on top. The staff member struggled to lift the person and we had to fetch another staff member to assist. The person was then safely moved to a vacant chair. We found many people were living with advanced dementia. We observed that staff were struggling to keep up with tasks which did not allow for very much social exchange with people. We observed staff being kind and considerate to people but at the same time staff were under pressure to get on with their jobs. This showed the delivery of care did not always meet people's individual needs.

We spoke with care workers about staffing levels. A care worker said, "Staffing levels are quite low. We all pitch in and it's normal to have to pick up extra shifts quite often. We look after people and the manager always pitches in but we are under pressure." Another staff member said, "People are safe here but care staff are very stretched. They do an extraordinary job under often great pressure. It often seems that [the provider] just piles more and more on carers. Now they even have to wash dishes, load and unload the dishwasher after meals. Of course we're all too busy looking after people for that so we just have to pitch in, but it takes time away from actually looking after people." Following our inspection the provider told us care workers were not expected or asked to carry out any ancillary tasks, for example, wash dishes and unload the dishwasher.

We found that sufficient numbers of suitably qualified, competent, skilled and experienced persons were not employed. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall the home was reasonably clean. We saw that communal areas, people's bedrooms, bathrooms, and toilet areas were generally clean and well maintained. There had been some refurbishment but a number of areas were looking very tired. We saw that some seating in the home was worn and stained, particularly in the lounges. The condition of this furniture also posed a risk to effective infection control procedures. Throughout the day there were times when there was a malodour along the corridors and in both the residential and nursing units. The condition of this furniture also posed a risk to effective infection control procedures. We fed back our observations to the registered manager. She informed us that the provider was

Is the service safe?

aware of the condition of the furniture and there was an on-going program of refurbishment in the home and approximately 75 percent of the armchairs had already been renewed.

We viewed medication administration records (MAR) for 20 people at the home. We found the records to be complete with no gaps and all medicines were available for people to take. Where medicine was not given, a reason was recorded. One member of staff told us, "We haven't had any problems with missed doses or medication errors but we'd know what to do if there was a problem or mistake." We asked a member of staff about the procedure that was followed if a person refused their medicine. They said, "It does happen occasionally but we monitor this very closely and involve their GP if it becomes a pattern, especially if they aren't eating or drinking either."

Medicines were stored safely and securely in medicine rooms and temperature checks were taken and monitored to ensure medicines were stored within the manufacturers recommendations. Damaged or unused medicine was recorded and returned to the pharmacist safely. We found that staff followed detailed guidance for people who received 'as required' medicine and that doses had been recorded appropriately.

We checked the audit and stock records of 'controlled drugs' for the six months prior to our visit. We found no discrepancies in the stock and administration of these drugs and that staff had an system in place to follow in case of an error in dosage. We spoke with a nurse about this who said, "Controlled drugs are only ever administered by two people, always a nurse and a senior carer. We have a really good standard of consistency here. The nurses make sure new staff have a good medication induction."

At the time of our inspection a new nurse for the service was undergoing her medication induction. We spent time observing this. We found that the nurse in charge was patient and explained the home's safety procedures clearly, ensuring that the new nurse could demonstrate competency in this area. We noted that both nurses used effective techniques to encourage people to take their medicine, treating people with kindness and respect.

We found safeguarding vulnerable adults and whistleblowing policies and procedures in place, including access for staff to South Yorkshire's local joint working protocols to ensure consistency in line with multi agency working. Staff told us and records seen confirmed all staff had received safeguarding vulnerable adults and whistleblowing training. Whistleblowing is one way in which a worker can report suspected wrong doing at work, by telling their manager or someone they trust about their concerns. This meant staff were aware of how to report any unsafe practice.

Staff were able to tell us how they would respond to allegations or incidents of abuse and the lines of reporting in the organisation. Staff spoken with were confident the manager would take any concerns seriously and report them to relevant bodies. They also knew the external authorities they could report this to, should they feel action was not taken by the organisation or if they felt uncomfortable raising concerns within the service. The manager had reported any incidents that were potentially safeguarding concerns to the Care Quality Commission (CQC) and the local authority in line with written procedures to uphold people's safety.

The service had a policy and procedure in relation to supporting people who used the service with their personal finances. Some people had asked the service to 'safe keep' a small amount of money for them. We saw the financial records kept for each person, which showed any money paid into or out of their account. The record was signed by the person who used the service or their advocate and senior staff at the home. Money held for people was checked by an external auditor each year. We found that people did not have access to their money if the administrator and registered manager were not on duty. We spoke with the registered manager about this and they said they would ensure there was a system in place so that people had access to their money at all times.

From looking at people's care plans, we found that staff had completed risk assessments that were comprehensive and tailored to people's individual needs. For example, we noted that risk assessments had been completed for a person who had demonstrated aggressive behaviour. A risk assessment had been completed that explained effective de-escalation techniques for staff to use, such as initiating calm conversation, encouraging the person to move to a different room and to recognise triggers to their aggression. We spent time observing how staff managed the risks to people in the home. We found that staff, in the main, had a good awareness of the risks to people and managed these effectively. For example, we saw a care worker assist a

Requires improvement

Is the service safe?

person to move from a lounge chair into their wheelchair. During this process the care worker was kind and reassuring, explaining to the person what they were doing and why. However we saw when a person threw their juice across the room and asked, "Why do I have to drink this?" a member of staff said, "Because you have to." This meant that not all care staff were aware of the agreed actions on people's individual risk assessments.

There were systems in place to ensure that new staff were suitable to care for and support vulnerable adults. We viewed the recruitment records of seven staff, including those recently employed. We found the provider had requested and received references, including one from their most recent employment. We saw application forms and notes from the interview process. A Disclosure and Barring Service (DBS) check had been carried out before confirming any staff appointments. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. We noted that the service did not have a policy in place regarding the updating and renewal of DBS checks. This meant that some staff who had worked at the home for over ten years had not had a new DBS check completed. We spoke with the registered manager about this who said the provider was aware of this and was currently considering this and deciding what action they would take in order to ensure people using the service were safeguarded.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The registered manager had recently applied for a number of people to have a DoLS authorisation in place due to recent changes in the legislation. We saw that not everyone who had restricted mobility or diminished capacity had a DoLS authorisation in place. A senior member of staff said, "The new legislation means that more assessments need to be done. The best interests assessments need the registered manager, a nurse, the person's GP and their family to be involved. This is very time consuming and we're progressing but it takes time."

Although training was provided to staff about the MCA and DoLS, two staff members we spoke with were unclear about the MCA and were unable to describe what it meant. One staff member believed no-one had a DoLS authorisation in place at the service, although this was not the case, which meant they may be unclear what restrictions were in place for people.

We looked at the care plan of a person who a nurse told us sometimes received covert medication. This means that they were administered medication for which they had not given their consent. We found that the person had undergone a mental capacity assessment and had been found to lack the ability to make their own decisions about medicine. Although the care plan stated that the person's family and GP had agreed to them receiving covert medicine when they refused to take it themselves, there was no documented evidence of a 'best interests meeting'. There were also no notes from medical professionals to state that they had given their authorisation for covert medicine. We spoke with the registered manager about this. She told us, "I think the best interests meeting took place by phone because we couldn't get everyone together. [Person's] family signed their care plan to agree to covert medicine and the GP was consulted by phone. This was a last resort decision based on the risks we identified because the person frequently refuses to take their medicine."

Our findings showed that the arrangements in place for obtaining consent for decisions did not follow the principles of the MCA 2005. As such, it could not be demonstrated that decisions were always being made in line with people's best interests. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed part of the lunchtime meal in both the nursing unit and the residential unit. In the nursing unit there were seven people in the dining room and variably two or three staff members. Three people required assistance with eating. One person was eating chilli and rice with a large spoon but kept missing their mouth and the rice was all over the table. The person had a beaker with fruit juice in and kept trying to use their spoon to get the fruit juice out of the beaker to drink. The person would have benefitted from closer observation or assistance but available staff were overstretched. A number of people remained in the big lounge and there were three staff in there assisting people to eat. One staff member told us, "We always have to have somebody from the other unit at mealtimes to help us but even then it's a struggle to help everyone."

In the residential unit, most people were in the dining room and were able to eat without assistance. However there were two people who were not eating very well. One person had some pudding in front of them which they were just looking at and another person had some soft food which they were struggling to lift from the plate. There were two staff members plus one person from the kitchen in the dining room and they were calling across to a person, "Come on, try some more dinner." There wasn't a lack of kindness but staff were trying to clear away pots and seemed over committed to basic housekeeping work instead of being able to focus on supporting people.

We did not see anybody either have or be offered a hot drink with their meal. We were told people could have a cup of tea if they asked for one. This was not immediately obvious and the choice wasn't offered. People spoken with told us they didn't know this.

Is the service effective?

During the morning and afternoon, drinks were brought round but there were no snacks such as cake or biscuits and no fresh fruit. One member of staff said, "We don't offer cakes because it would put them off their lunch or their tea." They also said, "I don't think there is enough variety in the menu and they don't cater for people with large appetites. Some of the gentlemen have a good appetite and they are filled up with plates full of vegetables instead of reasonable portions of meat. I think some of the menus need to be looked at."

We saw from looking at a care plan that staff had completed a risk assessment when a person had experienced rapid weight loss and was at risk of malnutrition. Although the risk assessment included detailed information to support staff in managing the risk of malnutrition, this person had not had their weight checked since December 2014. Staff told us that pressure caused by the time they had to spend on reviewing each person's care plan meant that this had likely been an unintended mistake.

The registered manager told us a MUST (malnutrition universal screening tool) was in place for people who were at risk of malnutrition and we saw evidence of this. The registered manager told us that six people who used the service had been identified as being at risk of poor nutrition. Staff had been asked to record the food and fluid intake for these people. We looked at the food and fluid charts for these people and found there were gaps in the information recorded on five charts. For example there was no record of any food or fluid taken by people during the night. This meant that in some instances people's charts showed that they had not taken any food or fluid for as much as 16 hours. The sixth person did not have any record of their food and fluid intake.

Our findings showed that people were not always supported to have adequate nutrition and hydration. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service had access to healthcare professionals to make sure they received appropriate care and treatment to meet their individual needs. Records showed that people who lived at the care home had access to doctors, dentists and chiropodists to manage on-going healthcare needs. Staff we spoke with during the inspection had a good knowledge of the individuals they supported. Staff were able to give us information about people's needs and preferences which showed they knew people well.

We spoke with seven staff about their experiences of training and induction. In most cases we found that staff were happy with the training they had received and felt that it helped them to meet the specialist needs of people who used the service. One care worker said, "Training is very good. It's specialised enough for the people we look after here. They've [provider] cut the time we spend on training so it doesn't feel as detailed but the trainers are brilliant and really know what they're doing." Another care worker told us, "The manager is on the ball with training, we can always ask for anything extra we need and she'll get it for us." Another staff member said, "The training is decent enough but I really feel that it could be more in-depth. Especially when staff are on the nursing floor, they need more training in how to look after people with dementia." One care worker said, "The training is really good. I'm not new to working in care but this stands out as good training. Especially with support from the manager, you get to see how the training works in practice very quickly." Following the inspection the provider told us that there had not been any cut in the time provided to staff for training.

Care staff had been trained in subjects including safeguarding of vulnerable adults, the Mental Capacity Act (2005), the Deprivation of Liberty Safeguards (DoLS), infection control, hygiene, moving and handling and dementia care. We found that most staff had been trained in caring for people with complex or challenging behaviour but two care workers who had joined the service recently had not been provided with this.

During our visit we noticed that a care worker was not able to deal effectively with a person who demonstrated complex behaviour by swearing at them and throwing a drink across the room. We found that this was because the member of staff had not been trained to handle such situations but that other care staff were able to quickly de-escalate the situation. We asked a care worker about this, they said, "We do get a lot of challenging behaviour, especially on the nursing floor. I think we're well equipped to help people in these situations and the manager and nurses are always there to help. We have had dementia training and we get to know people well so we can keep an eye out for triggers of aggression."

Inadequate

Is the service effective?

We asked two new care workers about their induction and training. One care worker said, “I’m very positive about my initial experience at this home. It’s a really friendly team; they’ve made me feel very welcome indeed. When I started I had two days of shadowing. This was very useful; it definitely helped me to get to know people well.” Another new care worker told us, “I had three days of shadowing that was really useful because it was with a very experienced member of staff. They were really patient with me and I got to know people quite well.”

We spoke with care workers about how they were supervised and supported. We found that the registered manager conducted annual appraisals of all staff and that a senior care worker or nurse conducted bimonthly supervisions. One care worker said, “I think supervisions and appraisals are useful ways to support us and make sure we’re doing a good job.” Another care worker said, “Our supervisions work well, the manager listens to us and has always acted on any problems I’ve brought up.”

Good

Is the service caring?

Our findings

During our inspection we spent time observing how staff spoke with people living at the home. We saw that in all cases people were cared for by staff who were kind and demonstrated a good understanding of their needs. For example, we saw that a person who needed assistance to get to the toilet was embarrassed by this. The care worker who assisted them was kind and compassionate, talking to them as a distraction technique and ensuring that they did not feel uncomfortable by accepting help. One person told us, “I love it here. I go to bed at night and I’m not frightened. I don’t like being on my own so it’s wonderful to have so much company.” Another person said, “Staff are okay but I do get fed up. I don’t do anything and people don’t really talk much.”

We saw that staff spoke to people with dignity and respect and communicated with language that was tailored to each individual. Staff were observant and attentive to people’s needs. We saw that a care worker noticed a person slouching in their chair and encouraged them to move by saying, “Are you ready to move love? We’ll find you a more comfy chair over here.” We saw that the use of familiar, informal language was very reassuring to the person.

All assistance with personal care was provided in the privacy of people’s own rooms. People were able to choose their clothing but staff assisted people to make sure that clothing promoted their dignity. Many people who lived at the home were unable to fully express their views verbally. The staff used pictures, signs and objects to assist people to make choices and express their views.

We did not see or hear staff discussing any personal information openly or compromising privacy and we saw staff treated people with respect. Two members of staff were trained as ‘dignity champions’. They had attended training workshops and then arranged ‘dignity meetings’ with people who used the service and staff from the home. Staff told us that the issue of privacy, dignity, confidentiality and choice was discussed at training events and at staff meetings that were held. They were able to describe how they maintained people's privacy and dignity and how important this was for people. Another member of staff had completed a ten week training course to become a ‘dementia friend.’ The registered manager told us the staff member had given feedback to other staff about what they had learned during their training.

Care plans seen contained information about the person's preferred name and identified the person's usual routine and how they would like their care and support to be delivered. The records included information about individuals' specific needs and we saw examples where records had been reviewed and updated to reflect people's wishes. Examples of these wishes included meal choices and choosing the social activities they wanted be involved in.

People who used the service could not recall being involved in their care planning, but none of the people we spoke with wanted to be more involved. One relative told us they had been fully involved in the care planning and regular reviews for their family member.

The registered manager told us and we saw evidence that information was provided to people who used the service about they could access advocacy services if they wished. An advocate is a person who would support and speak up for a person who doesn’t have any family members or friends that can act on their behalf. The registered manager told us about a person who had been allocated an independent advocate to support them following a DoL’S assessment.

The registered manager said that visiting times were flexible and could be extended across the 24 hour period under certain circumstances and with the agreement of and the consent of the person using the service. Relatives we spoke with said they visited every week, at various times and were always made to feel welcome. One visitor told us, “People are definitely supported to maintain their faith here.”

Good

Is the service responsive?

Our findings

People and relatives we spoke with felt that staff knew their, or their family member's, preferences well. Staff we spoke with were able to describe the needs of the people they cared for. They told us they knew most people well and had involvement with families which guided them as to how people liked to be supported. They said that they read care plans for new people to become knowledgeable about their needs.

The registered manager said that care plans were reviewed monthly and in response to any change in needs. She informed us that the new care plans recently introduced made sure that family members and other relevant professionals were invited to formal reviews. In one care plan we saw the person's relative had been involved in a recent review of care. Staff were also completing 'life history' work with people and their relatives. This was information gathered about the person's lifelong interests and hobbies. The registered manager said this would be used to help to provide people with bespoke person centred care.

We observed staff taking time to involve people in conversation. They adapted the way they communicated with people so they were able to understand them. Staff sat down next to people and asked them how they were feeling and if there was anything they needed. Throughout the home there was a positive atmosphere and we saw good interactions between staff and people who used the service.

All staff were included in the daily handovers which took place at the beginning of each shift. This meant they were familiar with people's immediate needs and able to provide continuity of support for these. The home was divided into two units and staff worked on an allocated unit each day. The senior member of staff 'handed over' to staff, giving them information about how each person was, if there were any changes to their care and for example if they had any appointments they needed to attend. This information was recorded and passed to the manager for them to check if any further action needed to be taken. Staff told us this was very useful and that they also arranged what additional specific tasks they would all be responsible for during the shift.

There was an activity co-ordinator employed. On the day of the inspection the activity worker was on holiday and the registered manager had asked other staff to provide activities for people, by working additional hours. We saw a member of staff taking a person out on an activity to an exercise class. There was a poster showing the regular weekly activities on each floor. One person told us, "The activities coordinator is excellent. She gets people singing and dancing. I've had manicures and pedicures. I've even had my toenails painted blue."

We saw there were some dementia friendly posters and pictures in some areas of the home, but we did not see any specific adaptations to the environment for people living with dementia, such as sensory areas, reminiscence areas, rummage boxes, photo boards, colour coding etc. We did not see any dementia specific activities taking place or advertised. This meant people who used the service, who were living with dementia did not have opportunities to take part in social activities that reflected their needs and promoted their well being.

Healthcare professionals told us they felt the staff at the home were responsive to people's needs. They said staff were always willing to listen to ideas to improve people's care and they acted promptly on suggestions made, such as referrals to other professionals.

The registered manager told us that resident and relatives meetings regularly took place and there was a good relationship with relatives who attended the home. She told us that minutes of meetings were provided to relatives, which was confirmed to us by one relative we spoke with. One relative told us, "There are regular meetings for residents and relatives about once a month but it's always the same three or four people who come. I know people work and the meetings are in the daytime but it's always the same faces."

All the people we spoke with told us that they didn't have any complaints or concerns but that they would know what to do if they had. People who lived at the home and relatives we spoke with told us that care staff were approachable. One person told us, 'If I wasn't happy about anything, I would tell the senior and if she didn't sort it out, I would tell the manager. She is very approachable and looks after everybody here." No relatives or visitors we spoke with had any complaints to make about the service.

Good

Is the service responsive?

The registered manager told us there had been five complaints reported to them in the last 12 months. We looked at the complaints file and saw evidence that all the complaints had been investigated and resolved. The complaints policy/procedure was on display in the home and included in the 'service user handbook' which each person had a copy of. The policy included the details of relevant organisations such as the local authority should people wish to raise concerns directly to them and included time scales for responses. We also saw the service had received numerous compliment cards or letters in the last 12 months.

Requires improvement

Is the service well-led?

Our findings

The service was led by a manager who was registered with CQC. The registered manager was supported by senior staff, a regional manager, the provider and their representatives.

During our inspection we spent time observing people in communal areas around the home. We saw that the manager was proactive in interacting with people and was well liked and respected by people, visitors and staff. For example, when a person appeared at the manager's office and wanted some help, the manager quickly and clearly prioritised their needs, offering a cup of tea and a chat. It was clear from our observations that the care and safety of people was the main priority of the manager. It was also clear that the manager knew people well and had a good understanding of their needs. We saw evidence of this when they were able to help people enjoy a sing-a-long because they knew each person's favourite song. One person who used the service told us, "The manager is always around. She knows everyone and doesn't hide away in her office."

Staff told us, and duty rotas for the care home confirmed, there was always at least one qualified nurse and senior care worker on each shift. Senior staff allocated workloads at the beginning of each shift which ensured that all staff knew their role and responsibilities for the day. The senior member of staff was responsible for ensuring that care was provided to an appropriate standard. They also offered support and guidance to less experienced staff.

We spent time speaking with care workers and the nurse in charge about management and leadership in the home. One care worker said, "We have monthly staff meetings for both dayshift and nightshift and the manager is always present. The meetings run very well. We can bring up any problems or concerns and we're always listened to." Another staff member said, "We have staff meetings regularly. They are quite useful and we separate care staff and nurses so that relevant information gets passed on to everyone."

Staff we spoke with said that they felt the team as a whole was stable and that they worked well together. Care workers told us that nurses were approachable and usually supportive when they needed help. We found that to make up shortfalls in the number of available nurses, the home did use bank nurses. A care worker said, "We do rely on bank nurses but we get the same people time and again. We're very happy with them and they are great with the residents, they know them well."

A senior member of staff told us, "The manager is great, very supportive and really looks after us. The provider has just changed the way they want care plans written again. This is very time-consuming and takes us away from spending time with people." One care worker highlighted a concern about how staff were deployed and led on a day-to-day basis. They said, "We used to be assigned to a specific area so we could specialise in looking after certain people but now we change on a daily basis, which makes it more difficult to keep track of people's needs and moods."

There were various regular health and safety checks carried out to make sure the building was maintained to a safe standard for those people using the service, staff and visitors.

The registered manager and regional manager carried out monthly audits including auditing care records, medicines, staffing, complaints and safeguarding. This enabled them to monitor practice and plan on going improvements. We saw that feedback from these audits were included on the staff meeting agenda. This meant that any shortfalls identified could be discussed with staff and action plans put in place to address any issues.

All incidents and accidents which occurred were recorded and monitored by the registered manager. We saw that where a person had a number of incidents, action had been taken in partnership with other health and social care professionals. This showed the service had taken action to make sure this individual received effective support and treatment to meet their needs and maintain their well-being.

During our inspection we found the atmosphere in the home was lively and friendly. We saw many positive interactions between the staff on duty, visitors and people who lived in the home. The staff we spoke with told us they were proud of the service and the care provided.

People who used the service, relatives and staff were asked for their views about their care and support and these were acted on. We saw evidence the provider carried out satisfaction surveys each month. The surveys asked people and their relatives their opinions on a specific topic. The

Requires improvement

Is the service well-led?

most recent survey sent to people asked them about privacy and dignity. The information was then collated into a report which was shared with everyone who had an interest in the service.

The home had policies and procedures in place which covered all aspects of the service. The policies and procedures were comprehensive and had been updated and reviewed as necessary, for example, when legislation changed. This meant changes in current practices were reflected in the home's policies. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.

The managers' said they were aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. The registered manager confirmed that any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed this. They said they had an oversight of all incidents and reviewed these on a regular basis with referrals and notifications passed on to relevant organisations where required. They said they planned in the future to use this regular review to identify any themes or trends that may require addressing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person must take proper steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person must have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person must ensure that service users are protected from the risks of inadequate nutrition and hydration.**