Care Homes UK Two Limited

The White House Nursing Home

Inspection report

Monkton Lane
Jarrow
Tyne and Wear
NE32 5NN

Date of inspection visit: 9 and 16 February 2015
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Ratings

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

Overall summary

The inspection took place on 9 and 16 February 2015. The first visit was unannounced, which meant the provider did not know we would be visiting. The second visit was announced. We last inspected this service on 1 October 2014 and we found the home was meeting the regulations we inspected.

The White House Nursing Home provides personal and nursing care for up to thirty six people, some of whom are living with dementia. At the time of our inspection there were 19 people living at the home. The home transferred to the current provider in September 2014.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Prior to this inspection we received information of concern about the quality of care being provided. Particularly staff not being provided with relevant training, lack of stimulation for people, people sitting in hoist slings all day and people's toileting needs not being met. Staff were provided with the training they needed to deliver appropriate care. One staff member said training was, "Every fortnight." We saw on a number of occasions people had been left unsupervised in lounges, without interaction and stimulation from staff. We also observed during our SOFI observation that people did not receive regular interaction from staff. We saw some people were sitting in hoist slings when they were in the communal lounge. Both nurses we spoke with told us this was better for the people's wellbeing and safety.

People and family members told us the home was safe and were happy with the staff delivering the care. People commented, "Very safe, no concerns whatsoever", "I do feel safe", and, "Yes, definitely safe." One family member said, "Very good staff, I don't see any neglect about." People gave us positive views about the environment within the home. They said, "My room is good. I chose the pictures on the wall and I chose the wallpaper." One family member said the condition of the home was, "Quite good." Family members told us they had been involved in making decisions about changes to the home. We found the home was clean with no unpleasant odours.

People told us the staff were caring and treated them well. They said, "[Staff] treat you like their family", "Staff are nice", "Very good", "Brilliant, fantastic", "I am so content here. [My relative] chose well. This one hit the jackpot." Family members also confirmed their relative's received good care.

People, family members and staff told us the current staffing levels had a detrimental impact on people's care. However, the registered manager was aware of this and had recruited additional staff who were due to start their employment imminently. People told us, "Not enough staff, some are overworked", "Yes enough staff, could do with more for the dining room", and, "Girls are alright, they can manage. There are times when the girls are overloaded." There were systems in place to ensure new staff were suitable to work with vulnerable people. This included disclosure and barring service (DBS) checks and requesting references.

Medicines administration records (MARs) had usually been completed accurately. Where we identified gaps in people's MARs, the provider had been pro-active identifying and investigating these gaps. We saw accurate records were kept for the receipt and disposal of medicines. Medicines were stored safely. Only qualified and competent nurses administered people's medicines.

Staff had a good understanding of safeguarding adults and whistle blowing. They told us they knew how to report any concerns they had. They also said they would not hesitate to raise concerns they had. One staff member said, "I would feel confident to raise concerns. John [registered manager] would take action." Staff said previous concerns had been dealt with "really well" and had been "taken through the right channels." Previous safeguarding concerns had been dealt with in line with the provider's agreed procedures.

The provider undertook standard assessments to help protect people from a range of potential risks. Separate risk assessments were carried out where staff had identified risks that were specific to the person.

The provider undertook regular health and safety checks and these were up to date. This included checks on gas safety, lifts, electrical safety, electrical appliances, equipment, safety checks of people's bedrooms and fire safety. The home had emergency evacuation plans in place which were reviewed monthly.

Staff told us they had regular one to one supervision every three months and an annual appraisal. They told these included a discussion about their training and development.

Staff were following the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). Where required, applications had been submitted to the local authority for approval. Staff had a good understanding of their responsibilities under the MCA and knew when MCA applied to a person. People told us they were asked for permission before receiving any care. They said, "I do what I want. Staff don't demand", "Sometimes have to wait but not for long. Staff are reliable and will come back", and, "Staff ask me what

Summary of findings

would I like." We found on two occasions family members had signed documents on behalf of their relative rather than the person receiving the care. We saw no evidence from viewing care records that these people were unable to sign documents.

People were happy with the meals they were given. One person said, "Tremendous, best chef in the world." Another person said, "[The] chef is very capable." We observed some people did not always receive the support they needed to meet their nutritional needs in a timely manner. For example, one person did not receive support with eating and drinking in line with their agreed care plan. However, when people did receive assistance we saw staff were kind and considerate towards them. The home had received positive feedback following an external audit for improvement in screening people for poor nutrition.

People said they were supported to meet their health care needs. One person said, "Staff call the doctor quickly." People had access to a range of health professionals including the community nurse, the optician and the chiropodist. Staff said they supported people to attend routine health appointments.

Improvements were being made to adapt the environment to suit the needs of people living with dementia. These included displaying reminiscence and sensory materials on corridor walls, décor, signage and personalised information displayed outside people's rooms.

People said they were treated with dignity and respect. One person said, "[Dignity and respect] always, at all times", and, "[Staff] treat you like a human being." Staff described how they delivered care in order to maintain a person's dignity. This included closing bedroom doors, knocking on doors before entering people's bedrooms, always wearing gloves when supporting people, talking to people and explaining what they were doing and seeking consent before delivering care.

People told us staff were responsive to their individual needs. One person said, "No matter what I ask for or ask them [staff] to do, they never refuse. They say it's your care home, we work for you."

Staff had access to written information about people's preferences including their likes and dislikes. One family member said, "We went through likes and dislikes. They wanted to get a feel for [my relative] and what [my relative] was about. They are still learning about [my relative] and tweaking." Staff had developed life histories for each person which included details of people's families, where they were born, their previous employment, holidays, interests and preferences in relation to their care. People had their needs assessed when they were admitted into the home. This was a comprehensive assessment that was used to develop personalised care plans. Care plans were reviewed regularly. However, the record of the review was brief and did not provide a meaningful update of the continuing relevance of the support plan to the person.

People had opportunities to take part in activities when these were arranged. These included playing "old-time music", musical instruments, entertainers, 'Pets as Therapy' (PAT) animals such as dogs and miniature horses, movies, bingo and raffles. One person said, "It keeps us going." One family member said, "[Activity co-ordinators name] does a really good job interacting." They also said people "seem very involved."

People and family members we spoke with said they had no complaints about the care provided at the home. One person said they had, "No complaints but they [staff] would act on it straightaway." Another person said, "I would talk to staff, they would help." Another person said there was "nothing wrong." We saw there had been no complaints made about the service.

People and family members had opportunities to give their views about the service including regular 'Relative's and friend's' meetings and completing questionnaires. The feedback from previous consultation was displayed in the home's reception area.

The home had a registered manager. People and staff said the registered manger was approachable. One person said there was, "No problem with John [registered manager]. You can see him anytime you want." Another person said, "The manager is very good, I can talk to him." Another person said, "The manager is very nice, very friendly. He likes to hear what is going on. If something isn't right, he puts it right in a nice sort of way."

Staff told us, and records confirmed regular staff meetings were held and they were able to make suggestions during these meetings.

Summary of findings

People and staff said the home had a good atmosphere. One person said, “I really love it here, everybody gets treated the same.” Another person said there was “no nastiness at all.” Another person said, “Homely. Happy go lucky, everybody speaks to everybody.” One staff member said, “I love it, very relaxed. I like working here”, and, “Lovely atmosphere, very homely.” Another staff member said the atmosphere was “pretty good.” Another staff member said the home had a “nice” atmosphere. They said it was, “Small, friendly and close with families.”

We saw on entering the home, information about the home’s approach to ‘Dignity in Care’ was displayed prominently in the reception area.

The provider undertook a range of regular audits as part of its quality assurance programme. This included checks of care plans, staff files, the kitchen, infection control, ‘pressure sores’, medicines and a health and safety audit. These had all been successful in identifying areas for improvement.

The provider’s regional manager also carried out a regular three monthly monitoring visit and the registered manager carried out unannounced ‘out of hours’ visits. The provider and the registered manager had a clear aims for the future direction of the home. These were documented in the homes ‘Strategic Marketing Plan’ and ‘Home Development Plan.’

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?

Requires improvement

The service was not always safe. People and family members told us the home was safe. However, people, family members and staff told us the current staffing levels had a detrimental impact on people's care. Additional staff had been recruited and were due to start their employment imminently. There were systems in place to ensure new staff were suitable to work with vulnerable people.

Accurate records were kept for the receipt, administration and disposal of medicines. Medicines were stored safely. Only qualified and competent nurses administered people's medicines.

Staff had a good understanding of safeguarding adults and whistle blowing. They knew how to report concerns they had and said they would not hesitate to raise any concerns they had. Previous safeguarding concerns had been dealt with in line with the provider's agreed procedures.

The provider undertook standard assessments to help protect people from a range of potential risks. Separate risk assessments were carried out where staff had identified risks that were specific to the person.

Is the service effective?

Requires improvement

The service was not always effective. People were happy with the meals they were given. However, we observed some people did not always receive the support they needed to meet their nutritional needs in a timely manner. For one person, the support they received with eating and drinking was not in line with their agreed care plan.

Staff were following the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). We found on two occasions family members had signed documents on behalf of their relative rather than the person receiving the care.

People said they were supported to meet their health care needs. People had access to a range of health professionals and were supported to attend routine health appointments. Staff were provided with the training they needed to deliver appropriate care. They also received regular supervision and appraisal.

Improvements were being made to adapt the environment to suit the needs of people living with dementia.

Is the service caring?

Requires improvement

The service was not always caring. We saw on a number of occasions people had been left unsupervised in lounges without interaction and stimulation from staff. We also observed during a specific observation that people did not receive regular interaction from staff.

Summary of findings

People told us the staff were caring and treated them well. Family members also confirmed their relative received good care.

People said they were treated with dignity and respect. Staff had a clear understand of how they delivered care with aim of maintaining a person's dignity.

Is the service responsive?

Good

The service was responsive. People told us staff were responsive to their individual needs and could take part in activities.

Staff had access to written information about people's preferences including their likes and dislikes. Staff had developed life histories for each person. We found people had their needs assessed when they were admitted into the home and this was used to develop personalised care plans. Care plans were reviewed regularly.

People and family members we spoke with said they had no complaints about the care provided at the home. We saw there had been no complaints made about the service. People and family members had opportunities to give their views about the service.

Is the service well-led?

Good

The service was well-led. The home had a registered manager. People and staff said the registered manger was approachable. Staff were able make suggestions during regular staff meetings.

People and staff said the home had a good atmosphere. The home promoted its approach to 'Dignity in Care' through information displayed in the reception area.

The provider had a quality assurance programme which included a range of regular audits. We found these had been successful in identifying areas for improvement. In addition to the regular audits, the registered manager carried out unannounced 'out of hours' visits and the regional manager did a three monthly monitoring visit. The homes 'Strategic Marketing Plan' and 'Home Development Plan' identified aims for the future.

The White House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 16 February 2015. The first visit was unannounced and our second visit was announced. The inspection was carried out by an adult social care inspector.

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

We reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the local authority safeguarding team, the local authority commissioners for the service, the local Health watch and the clinical commissioning group (CCG). We did not receive any information of concern from these organisations.

We spoke with four people who used the service and two family members. We also spoke with the registered manager, two qualified nurses and two care assistants. We observed how staff interacted with people and looked at a range of care records. These included care records for three of the 19 people who used the service, medicines records for all people living at the service and recruitment records for five staff.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person commented, "Very safe, no concerns whatsoever." Another person said, "I do feel safe." Another person said, "Yes, definitely safe." Family members also confirmed they felt their relatives were safe. One family member said, "Very good staff, I don't see any neglect about."

Medicines records we viewed supported the safe administration of medicines. One person said, "Staff make sure I am taking my medicines." We viewed the medicines administration records (MARs) for all people using the service. We found these had usually been completed accurately. Where we observed gaps in MARs, we saw staff had been pro-active in identifying these gaps. We also saw action had been taken to investigate the reasons for the gaps. We saw accurate records were kept for the receipt and disposal of medicines. We also saw medicines, including those liable to misuse (controlled drugs), were stored safely.

The nurse on duty told us only qualified nurses administered medicines. They also told us the pharmacist linked to the home undertook competency assessments of staff with responsibility for administering medicines. This included staff answering questions about their practice and being observed.

Staff had a good understanding of safeguarding adults. They told us they had recently completed safeguarding training. Staff were able to describe the various types of abuse and were aware of potential warning signs. For example, a person becoming quiet or withdrawn and fear of particular people. Most staff knew how to report concerns. They said they would raise their concerns with the manager. Staff also knew about the provider's whistle blowing procedure including how to raise concerns. Staff told us they would not hesitate to raise concerns they had. One staff member said, "I would feel confident to raise concerns. John [registered manager] would take action." Another staff member said, "[The] service users are priority at the end of the day." Staff said previous concerns had been dealt with "really well" and had been "taken through the right channels."

We viewed the provider's safeguarding log. We saw two safeguarding concerns had been received in January 2015. These had been recorded in the safeguarding log and referred to the local authority as required. At the time of our inspection these were still being investigated and dealt with through the safeguarding process. Two previous concerns had been received in 2014. These had also been reported to the local authority in line with the home's safeguarding procedure.

The provider undertook standard assessments to help protect people from a range of potential risks including poor nutrition, skin damage, falls and moving and handling. Where a potential risk had been identified, a separate risk assessment had been undertaken which was specific to the person. The assessment identified the risk and the controls needed to keep the person safe. For example, for one person who was losing weight the controls were referring the person to a dietitian, giving supplements and offering regular snacks and drinks.

We received mixed views about staffing levels at the home. One person said the home was getting more staff. They said they [the provider] had been "interviewing for the last two weeks." Another person said, "Not enough staff, some are overworked." However, they went on to say if they needed help, staff "would come quickly." Another person said, "Yes enough staff, could do with more for the dining room." Another person said, "Girls are alright, they can manage. There are times when the girls are overloaded." One family member told us staffing levels had "got better." They also said, "John [registered manager] makes sure people get their needs met. Staff will bend over backwards." The family member also said there was "less agency" staff being used. Another family member said there was "never enough staff."

One staff member said, "Meal times get busy. Extra staff 8 (am) until 2 (pm) to help with breakfast and lunches." Another staff member said staffing levels were "down at the moment but were supposed to be getting better." They went on to say they hoped this didn't impact on people using the service. Another staff member said there were, "Going to be a lot of changes. Two senior carers will be coming." This meant people, staff and family members all felt current staffing levels were impacting negatively on care delivery. However, everybody we spoke with all acknowledged the situation was to improve imminently with the employment of additional staff.

There were effective recruitment and selection processes to make sure new staff were suitable to work with vulnerable people. Staff files we viewed confirmed

Requires improvement

Is the service safe?

pre-employment checks had been carried out. For example, disclosure and barring service (DBS) checks to confirm whether applicants had a criminal record or were barred from working with vulnerable people. The provider had also requested and received references including one from the applicant's most recent employer. This meant people were protected because the provider always vetted staff before they worked at the service.

We received positive views about the environment within the home. People told us they were happy with their bedroom. One person said, "My room is good. I chose the pictures on the wall and I chose the wallpaper." One family member said the condition of the home was "quite good." They went on to say there were, "Lots of things John [registered manager] is fighting for, such as new windows and flooring." Family members told us they had been involved in making decisions about changes to the home. For example, when the day room was painted and new curtains had been bought. Family members told us the registered manager was also "getting the outside space sorted" with built up flowerbeds in the garden. One family member said the registered manager was "doing all sorts décor wise, lots of improvements." We observed improvements were on-going at the time of our inspection to improve the environment for people living at the service. We found the home was clean with no unpleasant odours.

We viewed a variety of records during our inspection which showed regular health and safety checks were undertaken and were up to date. This included checks on gas safety, lifts, electrical safety and electrical appliances. There were other records to confirm monthly checks took place of equipment, safety checks of people's bedrooms and fire safety. We found the home's fire risk assessment was still current. The home had emergency evacuation plans in place which were reviewed monthly. Most people living in the home had an individual assessment which detailed their support needs in an emergency. Although we found for one person this assessment was blank. We discussed this with registered manager who said they would arrange for the assessment to be completed.

Requires improvement

Is the service effective?

Our findings

People gave us positive feedback about the staff delivering their care. One person said, "Staff I come across are very good."

Staff said the provider was supportive of staff attending training. One staff member said training was, "Every fortnight." Records we viewed confirmed staff had either completed or were booked on training the provider considered was essential to their role. For instance, this included training in health and safety, dementia awareness, fire safety, infection control and moving and handling. Staff told us they had regular one to one supervision. This was usually every three months with the nurse in charge. Supervision is important so staff have an opportunity to discuss the support, training and development they need to fulfil their caring role. Another staff member told us supervisions took place when they were due. They also told us they could discuss training and development during their supervision. Staff also confirmed they had an annual appraisal of their performance.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals. We found the provider was following the requirements of the legislation. We found people had been assessed to establish whether a DoLS authorisation was required. Where required, applications had been submitted to the local authority for approval. For example, applications had been submitted for all people living at the home, apart from three who had been assessed as having capacity.

Staff had a good understanding of their responsibilities under the MCA. They were able to tell us when MCA applied to a person. They were also aware of the capacity of people within the home and described how decisions were made in people's 'best interests' where there were doubts about their capacity. Staff told us, and records confirmed staff had completed training on the MCA and DoLS within the last 12 months.

People told us they were asked for permission before receiving any care. One person said, "I do what I want. Staff don't demand." They went on to say they, "Sometimes have to wait but not for long. Staff are reliable and will come back." Another person said, "Staff ask me what would I like." Another person said staff, "Always ask. I am able to choose and make my own decisions." They went on to say if they declined, "Staff advise me, say they will come back in one hour and do check up on me to see that I am alright." We saw examples of signed consent within care records. For example, some people had signed their care plans to confirm they agreed with them. However, we found on two occasions family members had signed on behalf of their relative. This was even though the person had capacity to make their own decisions. We also found no evidence with the care records we viewed these people weren't able to sign for themselves.

Staff confirmed they would always ask a person for permission before delivering care. They said some people will tell you. For other people staff said they "act in their best interests." They told us some people had DoLS in place or other paperwork. Staff said they would ask people, "Do you need anything?" Another staff member said they gave people, "Choice and go by what they want." Staff said they would respect the person's decision. One staff member said, "We advise and talk about the benefits. You can't force somebody."

People gave us positive views about the meals they were given. They said staff had taken time to find out about their food likes and dislikes. One person said, "Tremendous, best chef in the world." One family member said, "Good variety [meals]. Very versatile. If you don't want what is on the menu, you can have something else." Another person said, "[The] chef is very capable."

Some people did not always receive the support they needed to meet their nutritional needs in a timely manner. We carried out an observation over the lunch-time to help us understand people's dining experience. During our observation we saw there were 17 people in the dining room with five staff initially supporting them. We saw four staff were providing one to one assistance to people, which left one staff member to support the other people in the dining room. Most people had their needs met appropriately. However, we observed three occasions when people did not receive the help they needed in a timely manner. For example, we saw one person had been in the

Is the service effective?

dining room for 45 minutes before receiving their meal. We also noted the meal they were served was not in line with the preferences specified in the person's care plan. This stated the person 'prefers finger food' and 'would like to be shown a pictorial menu.' However the person was given mince with mashed potato, which they refused to eat. We also did not see the person being offered the pictorial menu to make their choice. On another occasion one person was served their meal but struggled to eat it. This person had to wait for 10 minutes until a staff member had finished providing one to one support to another person, before receiving the help they needed. At other times staff were kind and considerate towards people. For example, staff said to people, "[Person's name] do you want a cup of tea?" [Person's name] I will cut this up for you", and, "[Person's name] do you want some more milk?"

Staff had a good understanding of people's nutritional needs. They were able to readily tell us about the support people needed with eating and drinking. This ranged from prompts and encouragement to full support. Staff told us the chef had a board in the kitchen which gave details of people's dietary requirements and their food likes and dislikes. Staff said people's weight was monitored monthly. They also said they looked at patterns and referred people to a dietitian where required. The registered manager provided us with a copy of an external nutrition audit which the local dietetics department had undertaken. The results of the audit were positive. The audit report stated the home were 'definitely showing excellent improvement with regards to screening their residents for malnutrition on a monthly basis.'

People said they were supported to meet their health care needs. One person said, "Staff call the doctor quickly." Family members also confirmed people's health care needs were met. One family member said, "Staff had acted on [my relative's] chest infection straightaway. The doctor came in and saw [my relative]."

Staff told us about the range of healthcare professionals involved in people's care. This included regular visits from the community nurse, optician and chiropodist. Staff said they supported people to attend routine health appointments.

We saw improvements were on-going to provide a good environment for the people using the service. This included adaptations to ensure the service was appropriate to meet the needs of people living with dementia. We saw reminiscence and sensory materials were displayed on corridor walls. For example, a clothes line and everyday objects such as garden implements, kitchen utensils and musical instruments. Reminiscence materials included war memorabilia, a blackboard and pictures of the local area in the past. We saw the home had been redecorated in such a way as to aid people's orientation. For example, with dementia specific signage and contrasting colours used for bedroom doors and handrails. Personalised information, or objects that were important to a person were displayed in special frames outside their room. For example, personal photos, DVDs and postcards.

Requires improvement

Is the service caring?

Our findings

People told us the staff were caring and treated them well. One person said, "[Staff] treat you like their family." One family member said, "Staff know each person individually. They will sit down and chat with people." Another person described the staff as "lovely" and said, "Staff are nice." Another person commented, "Very good." They also said the staff were, "Brilliant, fantastic." Another person said, "I am so content here. [My relative] chose well. This one hit the jackpot." They also commented about how they were treated, "Champion, like their [staff] own grandma, mother or older sister. Nice people." One family member said staff were, "Always very helpful."

Prior to this inspection we received information of concern about the quality of care people received. This included people sitting in the communal lounge all day with nothing to do, a general lack of stimulation and people sitting in hoist slings all day. We checked in the lounge areas at various points throughout our inspection. We saw on a number of occasions people had been left unsupervised without interaction and stimulation from staff. We discussed these concerns with the registered manager who acknowledged this was an area that needed improving. The current staffing levels impacted on the availability of staff to provide meaningful one to one time with people. However, staffing was to be increased imminently which would provide additional time and enable staff to better meet people's social needs.

Some people told us they had one to one time with staff. One person said, "Staff often have a chat, very nice. I think I get good care." Another person said, "Not really. If I asked for it though [one to one time] it would be done." One staff member said, "We have time for residents. Residents get plenty of care and attention." Another staff member said, "We try and make time for people." Some staff said they felt people would be better engaged if they had more one to one time.

We saw some people were sitting in hoist slings when they were in the communal lounge. We spoke separately about this with the two nurses who were on duty. Both nurses told us this was better for the people concerned. This was because they would be better protected from the risk of skin damage and they would also be more comfortable.

We carried out an observation for 30 minutes in the upstairs communal lounge, using the Short Observation Framework for Inspection (SOFI). We saw at the start of the observation there were four people and no staff members in the lounge. The TV picture was on with the sound turned down and music was playing in the background. During our SOFI observation we tracked all four people to observe the interactions they experienced and record their 'mood' state throughout the observation period. We saw for the first 15 minutes of the observation staff weren't present in the room. This meant people did not receive any interactions from staff and weren't being supervised. During this time one person was asleep, two people were looking at the TV and the fourth person was looking around the room and shouting out. After 15 minutes people started to receive positive interaction from staff. For example, the activity co-ordinator came into the lounge to chat with people. The activity co-ordinator told people about an arts and crafts session planned for later in the day and encouraged them to take part. We later saw people in the lounge engaged with this activity. People were also offered a cup of tea and then spent time chatting with staff.

People said they were treated with dignity and respect. One person said, "[Dignity and respect] always, at all times", and, "[Staff] treat you like a human being." Family members told us staff treated their relative with dignity and respect. One family member said staff treated their relative with, "Total dignity and respect. It is all about their dignity." They also went on to say staff were "Very dignified and don't gossip." One staff member said, "I have never heard anybody belittle anybody, staff speak politely. Staff are lovely." Staff described how they delivered care in order to maintain a person's dignity. They gave us practical examples of how they aimed to achieve this. For example, closing bedroom doors, knocking on doors before entering people's bedrooms, always wearing gloves when supporting people, talking to people and explaining what they were doing and seeking consent before delivering care.

We asked staff to describe the care provided in the home and to tell us what the home did best. They said, "Caring for each individual's needs. We do pretty well with everything", "We do well in most things", and, "Care is really good, food is good, atmosphere is good."

Good

Is the service responsive?

Our findings

People told us staff were responsive to their individual needs. One person said, "No matter what I ask for or ask them to do, they never refuse. They say it's your care home, we work for you." The person gave us examples of when staff had responded to their requests, such as when they had wanted to get up during the night or go out. They said they had asked, "Could I get out of bed and I was helped out of bed." They also said, "If I ask to go out to the shops, they take me." Another person said staff did anything they asked and described how staff supported them with their daily living. They said, "[Staff] get bed clothes out and help me to get dressed." They also said, "When I get up in the morning staff are always pleasant."

One person and one family member said they had been asked about their likes and dislikes. The family member said, "We went through likes and dislikes. They wanted to get a feel for [my relative] and what [my relative] was about. They are still learning about [my relative] and tweaking."

Staff said they had access to information about people's preferences from viewing their care files. For example, care records included background information about each person, such as their preferred name, their next of kin, GP and their allocated key worker. They told us they had gathered this information from talking to people, their family members and looking at old photos. Staff told us about one occasion where they had discovered from looking at photos, that one person had an interest in bowling and horse racing. Staff had built up a collage for the person to use as a reminiscence board. Staff had also developed life histories for each person. Life histories are important, especially for people living with dementia, so staff can better understand the care needs of the people they are looking after. This included details of people's families, where they were born, their previous employment, holidays, interests and preferences in relation to their care. For example, one person particularly wanted to have their hair done every week.

People had their needs assessed when they were admitted into the home. This was a comprehensive assessment that considered a range of needs. For instance, maintaining safety, communication, mobility, personal hygiene, eating and drinking. The initial assessment was used to develop personalised care plans. These were written from the perspective of the person receiving the care. For instance, 'I would like assistance with brushing my hair', and, 'I would like a regular hairdresser' and 'You can help me by brushing my hair on a morning and not using hair products.' Each person had a 'night profile' within their care records which also detailed their preferences. For instance, their preferred bedtime, preferred bedding, number of pillows and whether the person wanted any snacks or an early morning cup of tea. We found people's care plans were reviewed regularly. However, the record of the review was brief and did not provide a meaningful update of the continuing relevance of the support plan to the person. For example, staff usually recorded a brief statement such as 'no changes' or 'remains effective.'

People and family member gave us examples of activities that were available to do. This included playing "old-time music", musical instruments, entertainers, 'Pets as Therapy' (PAT) animals such as dogs and miniature horses, movies, bingo and raffles. One person said, "It keeps us going." One family member said, "[Activity co-ordinators name] does a really good job interacting." They also said people "seem very involved." We saw an album containing photos of people involved in activities was available to view in the reception area.

People and family members we spoke with said they had no complaints about the care provided at the home. One person said they had, "No complaints but they [staff] would act on it straightaway." Another person said, "I would talk to staff, they would help." Another person said there was, "Nothing wrong." We saw there had been no complaints made about the service. However, the provider had a system in place to log and investigate complaints should they be received.

People and family members had opportunities to give their views about the service. 'Relative's and friend's' meetings were held regularly. We saw the date of the next meeting was displayed in the home's reception area. We also saw the feedback from consultation from people and staff members was also displayed in the reception area. We saw there had been 11 responses from people using the service and 18 from staff. Most of the responses were positive. The findings from previous year's consultation were also available to view in the reception area.

Good

Is the service well-led?

Our findings

The home had a registered manager. The registered manager had been pro-active in submitting statutory notifications to the Care Quality Commission. One staff member said, "The manager is lovely. If you have a problem he will sit and listen, whether personal or work." Staff told us regular staff meetings were held. They said they were able to make comments and suggestions during these meetings. We viewed the minutes from previous staff meetings which confirmed these took place regularly.

People told us the registered manager was approachable. One person said there was, "No problem with John [registered manager]. You can see him anytime you want." Another person said, "The manager is very good, I can talk to him." Another person said, "The manager is very nice, very friendly. He likes to hear what is going on. If something isn't right he puts it right in a nice sort of way."

People and staff said the home had a good atmosphere. One person said, "I really love it here, everybody gets treated the same." Another person said there was "No nastiness at all." Another person said, "Homely. Happy go lucky, everybody speaks to everybody." One staff member said, "I love it, very relaxed. I like working here", and, "Lovely atmosphere, very homely." Another staff member said the atmosphere was "Pretty good." Another staff member said the home had a "nice" atmosphere. They said it was, "Small, friendly and close with families."

We saw on entering the home information about the home's approach to 'Dignity in Care' was displayed prominently in the reception area. This included the home's priorities and aims around dignity which included a zero tolerance to all forms of abuse, supporting people with respect and treating each person as an individual. The information then went on to show what each of these priorities meant in terms of the care provided at the home. For example, treating people with respect meant offering a personalised service through developing appropriate attitudes and behaviours, taking time to get to know the person and then tailoring the service to the person.

There was a structured approach to care plan audits. Records showed these were done regularly. We viewed the findings from the most recent audit dated February 2015. This showed eight care plans had been reviewed. The audit had been successful in identifying issues and ensuring action was taken to improve people's care plans. We saw an action plan had been developed for each person where required. For example, for one person this meant undertaking a social assessment, developing an additional care plan and giving formal consent to various documents.

The provider undertook a range of regular audits as part of its quality assurance programme. This included checks of staff files, the kitchen, infection control, 'pressure sores', medicines, incidents, accidents and a health and safety audit. These had all been successful in identifying areas for improvement, such as gaps in medicines records, increasing the frequency for cleaning bathrooms and additional training needs. However, we found it wasn't always possible to tell from the records that all of these actions had been completed, as some records had not been signed off.

The provider's regional manager also carried out a regular three monthly monitoring visit. We viewed the findings from the most recent visit which had been carried out in January 2015. This included checking a sample of records including staff files and care plans. The visit also involved speaking with people using the service and staff. We saw one person had commented, "The food is excellent, the staff are fantastic, what more can I say!" We also saw staff had identified they needed more time to allow people to make their meal choices. The registered manager carried out unannounced 'out of hours' visits. We viewed the 'out of hours' visit file. This showed the last visit was August 2014 and no action was required as a result of the visit.

The registered manager provided us with a copy of the homes 'Strategic Marketing Plan' which identified specific targets for the forthcoming year. This included increasing the occupancy levels in the home, continuing with the systematic redecoration programme, organising local events and continuing to implement person centred care planning which reflected people's wishes. The registered manager also showed us the home's most recent 'Home Development Plan.' This identified specific actions and provided the current status for the action. Examples of completed actions included fitting window restrictors and recruiting additional staff resources. Where actions had not yet been completed the current status, in terms of whether the action was 'on target' or 'not on target', was identified on the plan. This meant the provider and the registered manager had a clear aims for the future direction of the home.