Care Quality Commission

Lanemile Limited

Tall Trees

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 12 October 2015 and was unannounced. The service provides accommodation and nursing care for up to 48 people, providing accommodation over two floors. Most people had a diagnosis of dementia.

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

During this inspection we saw a mixed picture of care. The manager had been in post for about a year and was responsive and knew people's needs well. Audits around

Summary of findings

the quality and effectiveness of the care being delivered were robust but did not always reflect the experiences of people living in the home. We also found that care records did not always reflect people's needs accurately.

Staff were hard working but were unable to give people the care they needed in a timely way and care was not centred around the needs of individuals because staff had not received in-depth training on providing high quality dementia care. There were very few strategies recorded on how to pre-empt and understand people's behaviours in order for staff to respond appropriately. Other training for staff was of a sufficiently high standard and there were systems in place to ensure staff got appropriate support. Recruitment and staff induction was robust.

Risks to people's safety were reduced as far as possible but at times risks to people increased because they were not adequately supervised which was necessary due to some people's behaviours and anxieties.

Staff knew what actions to take to promote people's care and welfare and how to respond to any allegations of abuse, or identified concerns.

Staff were competent in giving medicines safely and had received appropriate training. People's medicine records did not give specific instruction as to when staff should administer medicines when required to help reduce people's anxiety or distress

Staff encouraged people to eat and drink enough for their needs and this was monitored. People were given appropriate dietary choices and staff monitored what people ate but records were not always sufficiently robust to show how people's dietary risks were being managed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The manager had a good understanding of the MCA and DOLS and was acting lawfully. Staff supported people appropriately to enable them to make decisions where they were able to do so. Consultation with people using the service and their families took place on a regular basis and there were a number of ways in which families were involved and consulted about the care needs of their family member.

People received good health care and access to relevant health care professionals but staff needed more guidance around providing better palliative care.

Relatives told us that staff were kind and attentive to their family members. We observed mostly positive practices and staff attending to people's physical care needs but less so to their psychological needs. People's dignity was preserved apart from one poor observation of practice which was referred to the manager to deal with.

Relatives told us they were involved and consulted about the standards of care within the home and their family members care. Some people using the service would be able to give their views and were encouraged to do so.

Activity hours were generous but we were unable to see how these were used effectively to ensure people received the appropriate amount of stimulation and activities centred around their needs, abilities and past interests.

The manager demonstrated strong leadership skills and was working hard to improve the service and consult with a range of people, their families and health care professionals in terms of how to improve the service.

Audits were robust however; we identified areas for improvement across the service particularly in terms of staff knowledge.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not always safe.

There were insufficient numbers of staff available at all times to ensure people were kept safe and their needs were met.

Risks to people's health and safety were documented but control measures were not always effective in controlling the risk.

People received their medicines safely by staff who were adequately trained. There were not always protocols in place as when to administer medicines to help keep people calm and reduce anxiety.

Staff received training in safeguarding adults from the risk of abuse and were familiar with adult safeguarding policies and procedures.

Is the service effective?

Requires improvement

The service was not always effective

Staff had the training and support they needed but we found gaps in terms of their knowledge around the specific needs of people using the service.

People were given appropriate choices around their dietary needs and preferences. However, the records used the monitor unintentional weight loss and fluid intake were not sufficiently robust to enable staff to effectively evaluate these.

Staff had enough understanding of the Mental Capacity Act 2005 and how to support people who were or not able to make decisions about their health, care and welfare.

People had access to appropriate health care services.

Is the service caring?

Good

The service was caring.

Staff upheld people's dignity and were kind and caring. Care observed was more task led than person centred.

Relatives and people where able were involved in their care decisions and decisions about how the service was provided

Is the service responsive?

Good

The service was not always responsive.

Records did not always reflect people's needs accurately.

Summary of findings

Observations of care did not tell us how staff were responding to and planning care around individual needs and staff lacked an understanding of how to deescalate behaviours which could challenge.

Is the service well-led?

Good

The service was well led.

The manager engaged with people and their relatives to gain feedback about the service and people's care and when possible these were addressed.

There were systems in place to judge the effectiveness of the service delivered. Gaps in care provision were being addressed.

Tall Trees

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 12 October 2015 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had personal and professional experience of dementia.

Before our inspection we looked at information we already held about the service including notifications which are important events affecting the well- being and, or safety of people using the service the home is required to tell us about by law. We received a provider information return (PIR) prior to this inspection. 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. This was well written and informative.

As part of this inspection we observed care in all areas of the service, including activities and lunch time. We spoke with fourteen relatives, six people and eight members of staff, including care staff, and nurses. We looked at two people's care records.

Requires improvement

Is the service safe?

Our findings

The provider told us they had enough staff and used a tool to determine how many staffing hours they needed to provide to meet people's needs. However this did not always match with people's experiences and staff were not always employed effectively. A relative told us there were usually enough staff and told us they saw the same faces but would like to see staff spend more one to one time for people which they said their family member would really benefit from. Another relative told us, "They are sometimes very short staffed and under pressure to cope. They bring in a lot of agency, (especially at night) but that means that full time staff are having to stop and show them what to do." Another visitor told us, "I do feel they are short staffed at times in fact I know they are because I have overheard staff saying that and during mealtimes there seem to be lots of staff around, but between those times there is a definite lull in staff presence." Ten visitors commented on the home being short of staff at times.

We spoke with four relatives who told us that communal areas were sometimes left unattended by staff for up to 20 minutes at a time. Relatives said they felt personality responsible for the safety and well-being of people using the service and did not feel they could leave the communal area until staff were present. This was supported by our observations. In the morning all staff were supporting people getting up and no staff member had been identified as being responsible for communal areas. Relatives told us they had witnessed incidents within the communal areas which could have been avoided if staff were deployed to cover these areas at all times. Visitors expressed concern as to what was happening during the times they were not there, and felt that people alone in their rooms were particularly vulnerable. Bedrooms were locked when people vacated them so people tended to be in the communal areas. Staff told us there was an expectation for staff to be present in the communal area but said this was not always possible.

People's records demonstrated that at times people living with dementia on both floors needed additional staff support when they became distressed, angry or frustrated. A relative told us that they sometimes arrived to find their family member undressed and in need of personal care support. Two relatives told us that when they arrived at mid- day or sometimes just before lunch their family member was not up and they felt this was to do with the number of staff rather than their relative's choice. During our inspection we saw some people were still in bed just prior to lunch and one of the activities coordinators was assisting care staff rather than providing structured activity which meant some people who were up were left unoccupied throughout the morning. We saw very little in the way of stimulation for people and care staff reported they were rushed.

We looked at the staffing rotas and the homes dependency needs assessment tool. This calculated how many staffing hours were required to meet people's needs. The manager said they were ten percent over the number of hours they needed. We saw that the home had the number of staff it said it needed on the day of our inspection. We also found that new staff being inducted and a deputy manager were available in addition to the required staffing numbers. However we found that staff were not always deployed in an effective way to ensure that people's needs were being met. When staff were absent from the service, agency staff were used to cover these vacant hours. Staff told us the same agency staff were used so they were familiar with people's needs. However we found that staff were rotated around the floors and were not always familiar with people's needs. The manager explained this was to enhance the care given to people but several relatives told us it resulted in disjointed care and meant that when they had raised concerns about their family members care they did not always get an answer because staff were not sufficiently familiar with their needs. We were not assured that staffing levels were always adequate to people's needs or ensured people were kept as safe as possible and given the care and support they needed in a timely way. There were a number of gaps in the rota and on the day of our inspection there were two agency staff working to cover staff sickness. There were 150 vacant hours plus two nurse vacancies and recruitment was on-going.

This demonstrated a breach of Regulation 18. Staffing which states, Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Most relatives were positive about the care given to their relative and felt they received safe care. One relative told us, "I feel she's safe here. They manage her hoisting safely and know how to reduce her anxiety whilst being hoisted." Another told us that there was an incident in the past when

Requires improvement

Is the service safe?

their family member was pulled from their bed by another person using the service. They said they had not been injured and the home had responded appropriately. The person now had sensors in place which alerted staff to any one entering the room. We asked them if they felt their family member was safe. They said, "Definitely yes."

Incidents were well managed following an event but steps to prevent them occurring in the first place were not always in place. The manager regularly notified us of incidents and demonstrated they had taken appropriate actions. Staff had a good understanding of how to keep people safe and who they should report and escalate concerns to through their own internal procedures and notification to other agencies. Staff had information they needed about how to recognise abuse and take corrective action and received regular training.

One relative raised concerns about pressure care and said their family member had developed a pressure sore and they did not feel they had been given adequate information about this. We discussed this with the manager who told us that the staff supervisions were currently being used to improve standards and consistency of practice in the prevention of pressure sores. People at very high risk of developing pressure sores had appropriate mattresses on the beds and pressure relief cushions on their chairs. Staff completed forms to demonstrate that they were turning people in bed on a regular basis. They were also using pillows and cushions to support and shift people's position from side to side when they sat in a chair all day. One person on Aspen had a grade 2 pressure sore on their heel that was healing.

People received their medicines safely. One relative said, "Medication is handled really well and comes on time." We observed staff giving people their medicines. These were administered by trained staff only and they were giving medicines correctly according to policy. They explained to people what they were doing and what the medicines were for and we saw they patiently waited until people had taken their medicines. In one instance we saw a person hold their tablets in their mouth having not swallowed them and staff did not wait with them until they had checked they had swallowed them.

There were protocols in place for prescribed when necessary medicines. Staff administering medicines had received a competency assessment following training. Staff carried out daily audits of Controlled Drugs and weekly audits of medicines that were not in blister packs. Medicines that were destroyed or returned to the pharmacy were accounted for. There were clear records of the rotation of people's skin patches to reduce the risk of skin irritation. We did not see any missing signatures on the medicine administration records (MAR) that we sampled. Staff were also using the reverse side of the MAR to explain why they were giving or omitting specified medicines.

The MAR folder had care plans related to giving people some medicines on an 'as required' basis. This related mainly to giving painkillers or sleeping tablets. However, there was no care plan for two people who at times needed medication to help with severe agitation. A clear care plan was particularly important as one person could not at times be given the medication, despite their agitation, when their risk of falls was extremely high.

Nurses completed medication audits on a daily basis where stock levels of medications were checked and photographs were checked to ensure they were still in date. The Deputy Manager and clinical lead completed weekly audits and the manager carried out random audit checks .

We looked at a number of staff files and these showed there were robust recruitment processes in place to ensure staff were only employed after the necessary checks had been completed. These included right to work in the UK, relevant qualifications, (PIN) number, job references, application form, including any gaps in employment, a police check and evidence of identification such as passport. This helped ensure that only suitable people were employed.

Requires improvement

Is the service effective?

Our findings

The home provided a specialist service for people living with advanced dementia. The home had three nurses with mental health qualifications on the Rowan unit downstairs. The home worked closely with community psychiatric nurse who was the care coordinator for most of the people on Rowan unit. They also worked closely with the consultant at a local mental health centre. All care staff spoken with had received dementia training but said this was not in much depth. A number of people had very complex needs and behaviour that could be extremely challenging. Four people in the home were receiving one to one care. However, none of the nurses or management team had completed advanced training in dementia care. The nurses we spoke with had only had one day of dementia care training. In addition to eLearning there was also a face to face dementia course we included role play. However not all staff had the opportunity to do this. This meant that they did not have the chance to discuss issues that may have concerned them and enable them to relate the training to the individual needs of the people they were caring for. Discussions during training and possibly at group supervisions would help to 'cultivate a sharing, reflective culture that focused on continual improvement and promoted safe practice'. (As advocated by the Nursing and Midwifery Council.)

Staff said they are not taught how to manage behaviour that challenges. This meant people's behaviour was not appropriately managed and there had been a high number of incidents which resulted in injury to other people using the service and staff. People were supported by more staff than we deemed appropriate because the staff did not have the skills to support people.

The manager told us they were working towards the Gold Standards Framework accreditation where they will be assessed for end of life care. This was because the home provided end of life care on a regular basis. The portfolio to be submitted for assessment was currently being compiled and the assessors were due to come at the end of October. During our inspection we saw end of life care documentation with no reference to the psychological support the person and their family might require. The nurse we spoke with had not received any palliative care training. There was therefore a lack of good practice and the person was not receiving the standard of palliative care that they had the right to expect in a nursing home.

Staff felt well supported in their job roles. The deputy manager had 12 hours of clinical contact on the units and the remainder was supernumerary time to support the manager. There was also a clinical lead who worked on the units. They carried out clinical supervision and observation of care practices as part of their role. They had six hours supernumerary time for clinical audits. The manager had a daily meeting for 10-15 minutes every day when the management team, two people from each unit and a representative from all the support teams met to discuss any issues or problems of the day. Staff said that they found it very useful and a good method of communication within the home.

Staff told us that initially they had a period of two weeks when they were supernumerary and worked with a more senior member of staff. The manager said that this period could be extended if necessary. They told us that supervisions were used for one: one support with staff. They were also used to improve standards and promote consistency of care practices. One of the nurses told us that they were getting the training and support they needed for professional revalidation. The manager said that they were liaising with Essex University to ensure that nurses received the appropriate clinical training and support to meet the requirements for revalidation

We observed lunch and saw this was well managed with additional support staff assisting. Most people needed one to one support. Food was served promptly and people were assisted at their own pace. Only a few people sat around a dining room table and there was little interaction throughout the meal time. The manager said they did dining room audits and would look again at the meal time experience for people. There was fresh fruit for people and food choices were promoted by picture menus, or by showing people alternative meals and asking them to choose.

People were supported with their dietary needs to ensure they were not unintentionally losing weight. One relative told us, "I am very happy" with the nutritional support provided by the staff. [My relative] had been very underweight when they were admitted to the home and had only been able to eat a soft diet. They have gained

nearly 10kg in six months and they are now eating a normal diet." They said that staff were "very patient" when assisting people with their meals and knew the food they preferred to eat. "They provide fresh vegetables and a roast on Sundays. They give out regular drinks." Another told us, "The food is very good, they almost give them too much, but better to air on the side of excess and they are always getting drinks, it is like a food and drink factory. They recognise the importance of giving fluids to ward off urinary infections. "One relative expressed concerns about their family member's fluid intake. They told us that staff assured them that their family member was drinking enough but that their fluid records showed no fluids taken at night. Another relative said, "I can only assume my family member has been given a drink because drinks are in their room. "They went on to say often there was nothing recorded. We did not check these individual records but identified gaps in record keeping in relation to what people were eating and drinking.

We looked at people's weight and nutritional records and identified that improvements were required. We looked at the Aspen unit 'weight monitoring' records from January to September 2015. 16 people had records of their weight for four to nine months. Of these people, five had lost between 3-5 kg, two had lost between 5-10kg and three people had lost between 10-16.2kg. (The weights on Rowan unit were generally much more stable. People had nutritional risk assessments and were weighed on a regular basis. People identified as losing weight were referred to the GP and dietician for advice. However, the nutrition records were not detailed enough to assess the adequacy of people's nutritional intake. Staff were frequently recording the food and drinks served but not how much people had actually eaten or drunk. This meant that the charts were not an accurate indicator of the adequacy of their diet or fluid intake. When people refused a meal staff were not always recording the alternatives offered or whether the next cup of tea was replaced by a nutritious drink and high calorie snack. Staff were not helped by the fact that the records had insufficient space for the information that needed to be recorded. There was no evidence that staff were consistently supplementing or fortifying people's diets when they had a low BMI or were losing weight. The manager told us people had fortified diets/drinks as required but standards of records keeping was poor and we were unable too see this recorded in every instance.

One person who was receiving palliative care told us, "I don't feel hungry but they don't give me anything to tempt my appetite." This person had lost over 15kg in eight months. This was mainly due to their medical condition. However, there was no evidence that staff were providing an individual diet that met their changing needs. Appropriate alternatives were not always being offered when they could not eat their meals. There was no evidence that they were being offered regular high calorie snacks and drinks that they liked in between meals. This person's nutritional needs were not being met.

This demonstrated a breach of regulation 14, Meeting nutritional and hydration needs which states The nutritional and hydration needs of service users must be met.

Staff were in the process of carrying out choking assessments on everyone in the home, as people with advanced dementia were at increased risk. The manager said that they were planning to assess everyone on admission and then refer people at risk to the SALT team. People identified as having swallowing problems received advice on the types and consistency of foods and fluids that it was safe for them to eat and drink.

We looked at a sample of care records that contained a do not resuscitate form, (DNAR) form completed. One was completed in consultation with their next of kin and senior staff. However, the other one showed no evidence that staff or their relatives had been involved in the decision making. An appropriate application for Deprivation of Liberty had been made for this person. They were continually trying to leave the home and had succeeded on at least two previous occasions. Additional safeguards had been put in place to minimise the risk of this occurring again. The nurse we spoke with, on Aspen, had a basic understanding of the Mental Capacity Act, as did other staff spoken with and training was provided. Mental Capacity assessment were in place for people with advanced dementia. It demonstrated that staff were making decisions about their day to day support in their best interests, when they could no longer do this for themselves. Visitors told us they had been involved with their relative's care plans and also reviews. A number of relatives told us that they have power of attorney for their family member and were consulted about decisions about the persons care.

The manager had a good understanding of Mental Capacity and was acting lawfully. They had made applications for

Requires improvement

Is the service effective?

everyone in the home in regards to a Deprivation of their Liberty because people had been assessed as not able to leave the home safely and therefore had their freedom of movement restricted. The application ensured any actions taken to detain people were lawful and subject to review. They had lots of information for staff about Mental Capacity, Deprivation of Liberty Safeguards and best interest decisions.

Staff told us that they had good support from the local surgery. A GP visited the home once a week and came to see people promptly at other times. People had regular chiropody and optical checks. Dental and hearing checks were arranged when needed. A member of staff accompanied people when they went to hospital if a relative was not available.

There was a chart for staff to record hourly visits to the person with palliative care needs but this was not completed every hour. Their plan of care showed no insight into their psychological needs and the need for increased communication. There was no mention of the additional support they and their family needed to come to terms with their life limiting condition. The person concerned felt that some staff were better than others and some chatted whilst others did not have a 'good attitude.' The GP had stopped all the medication for this person and prescribed the range of medicines to make them comfortable at the end of their life. They did not continue to receive the antidepressant and antipsychotic medication they needed to stabilise their mood. These medicines were restarted after an interval.

Relatives told their family members health care needs were met and said they had regular access to health professionals and medicines being administered professionally and on time. One person told us that recently they had been ill in the middle of the night and 'they', [staff] sent for a doctor right away. One relative said [Their family member] had been admitted to hospital with a urinary infection and had come out with an additional health problem, which they said the home had dealt with well. They said staff keep them informed if there are any changes to their relative's needs. Another relative said "If mum has any health problems at all, they let us know and keep us informed."

Good

Is the service caring?

Our findings

Relatives said that staff engaged with them and kept them informed about their family member's needs. One relative told us they were proactive in highlighting issues to staff and discussing any changes to their family members needs on a regular basis. They said they often directly communicated with the manager and was very positive about the standards of care and communication. A number of relatives said that they have a regular monthly meeting regarding their family member and were confident that issues raised were taken forward and addressed. Other relatives told us that although they were regularly involved in meetings on care plans they said the consistency of feedback regarding care is variable and disjointed. One relative said, "Some staff are very good at letting me know how my relative is doing, some aren't." They were also unclear about the keyworker system, if this was still operational or what happened when a named member of staff left. Relatives felt things had become more disjointed since staff had been required to rotate and work on both floors rather than all having a designated floor.

We observed how people were cared for and found that staff were kind but did not spend sufficient time with people but rather checked to see where people were and that they were safe. Two people able to comment said, "They, (the staff) are kind," and another person said, "The staff are nice, they look after me." There were lots of visitors in the home who on the whole made favourable comments about their family members care. One relative said, "The care is excellent... I feel she is never just left. It's a real family atmosphere, and staff are really nice to me and very helpful. When the care staff approaches her she puts out her arms to welcome them. Here I feel you have the personal touch par excellence." Another said, "The staff are good. I won't hear a word said against them."

One relative said, "The girls are caring and good, people's basic needs are met." Another said, "The girls do their best and work hard, but I don't think they spend any one to one time with our relative. The only person who does seem to spend time is the Occupational Therapist." Another said, "'They are also very good to dad when he visits as he sometimes gets emotional.

The quality of care is excellent, they have a very good team of people who work hard and everything they say is coming from the heart. I am pleased that this is where mum will eventually end her days."

One relative said, "Staff are good at preserving people's dignity. They tactfully provide a blanket if a resident is trying to remove some of their clothing in the communal area." One relative told us there were never enough chairs for visitors and when visiting their family member in their room they either sat on the radiator or commode. During our observations a visiting professional talked to a person and their family about their health care needs and proceeded to take bloods and give the person a flu jab. This was done in the communal area with lots of people around and did not respect the person's dignity or consider those around her. This was raised with the manager who told us they would speak with the professional to ensure this was addressed.

At lunch time we saw people had slip mats and plate guards and if they could eat independently were encouraged to do so.

Staff interactions were observed to be professional, polite and respectful but there seemed little engagement in terms of communication. We observed a number of people who had one to one support most of the time; staff were observed keeping an eye on them but disengaged. One staff was asked about the persons main needs and why they required one to one support and they were not able to give us much insight into the persons needed or behaviours.

Good

Is the service responsive?

Our findings

Staff told us that sometimes it took at least three staff to support people with their personal care as people could be reluctant and could hurt themselves or staff trying to support them. We were unable to see any clear strategies for staff to follow in terms of how best to support a person with dementia around their personal care needs. There was some generic guidance such as speak clearly to the person, but there was no specific information around the persons needs such as did they have a preference in terms of the gender of the staff, what their routines had been at home, what relaxed them and what caused them anxiety. We spoke to the manager about one person's behaviour and they said they were more anxious in the afternoon, but the possible reasons for this had not been explored. We saw for another person they had been very relaxed throughout the morning but when their face was wiped they became very distressed. More information would enable staff to provide more personalised, individualised care. We found it unacceptable that at times three or more staff provide personal care to people.

We heard one person screaming and shouting, staff told us it was because they did not like personal care. There were three care staff trying to support this person which we raised with the manager as we felt it could be excessive and also intimidating. We spoke with staff who told us they were required to give care to people. One staff said, "What can we do, if we don't keep people clean we could be accused of neglect." we observed another situation in which two care staff were trying to get a person to stand up, and they did not wish to so a third member of staff was called. They were unsuccessful and caused the person some distress.

This demonstrated a breach of Regulation 9. Person-centred care which states The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences.

We asked relatives about the care of their family members. One relative said "The home is excellent. They really treat people as if it's their home." Relatives were positive about the care given to their family members. One relative said "Staff respond to people's distress, however expressed. They don't restrain, they pacify and calm them."

We asked the same relative about their family members care plan. They said [my relative] is very well looked after. Staff adhere to the care plan. I had a meeting with the manager about the care plan that was very constructive."

The care we observed throughout the day was task focused and we saw little interaction between people and staff other than when assisting people with their personal care needs. We felt the atmosphere in the communal room was not very lively or stimulating and we observed people sitting in chairs in the lounge and staring out in front of them, or at the television, A programme about the Arctic was showing. No-one showed any interest in the programme and might have responded better to music or videos reflecting people's various interests. We did not see any magazines/books or toys to engage or stimulate people.

Planned activities were available seven days a week. There were 44 hours a week designated specifically for activities and there were two activity staff, one for each floor. Staff told us they were supported by a range of volunteers of the home and the staff were involved in fundraising to support activities. During our observations across the day on both floors we saw a limited activity programme such as nail care and one to one support to people to assist the care staff. There was programme of activities which was varied and included sensory sessions, craft, music and singing, and two church services a month. There was also a poster encouraging dressing up for Halloween but felt this activity for people with advanced dementia might not be appropriate, as ghosts, witches, monsters etc. wandering about could be quite frightening for people who are not able to put the activity into context.

In the afternoon there was a baking session which two people participated in. The activity was nicely but prescriptively run. Staff said 'This is what we are doing today. We are going to make jam tarts', rather than finding out what people would like to bake. One person said she didn't like jam and wanted to make lemon curd tarts, but was told 'We'll have to do that next time.'

Staff told us there was a sensory trolley which was taken round and the environment was stimulating with sensory pictures on the wall. A relative told us there was a new activity coordinator who was developing a sensory trolley with a range of objects to stimulate all the different senses. They said "[My relative responded really well to the sounds

Good

Is the service responsive?

of the sea and it obviously reminded them of our visits to the seaside." This was an excellent initiative to stimulate and interest people with advanced dementia and limited verbal communication.

The manager told us that during the summer periods they have trips out for the whole period and their maintenance person drives. They said people really enjoy this.

Care records were of a variable standard and were not person centred. They did not always provide a clear indication of people's needs, preferences and abilities or indicate how staff supported them to maintain their independence. The care records were extremely bulky and at times repetitious. They were also occasionally incorrect. One person's records stated that they could walk with a Zimmer frame. However, they told us and staff confirmed that they could not stand and needed a hoist to move. The records also stated that they were at risk of choking and should be on thickeners, when staff told us that they were not at risk of choking and no thickeners were needed. It would have been very difficult for new or agency staff to find key information about each person. The care needs summaries were not always up to date with people's changing needs.

This represented a breach of Regulation 17, Good governance which states the provider must maintain securely an accurate, complete and contemporaneous record in respect of each

service user, including a record of the care and treatment provided to the service user and

of decisions taken in relation to the care and treatment provided.

A relative told us they had raised a few concerns with the manager and felt that they were addressed very promptly and to his satisfaction. One relative told us they said they are not really sure who they should complain to, or what the procedure, but they always speak to the nurses. Most relatives said they had raised concern and these had been dealt with but not all relatives knew the outcome of concerns they had raised which was reflected in some relatives experience of communication sometimes getting lost in transit and disjointed with varying levels of response depending on whom they spoke with.

Complaints were logged and there was a clear process for acting on complaints and a record of what had been learnt as a result of the complaint. This reduced the likelihood of repeated concerns being raised.

Good

Is the service well-led?

Our findings

The current registered manager had been in post for about a year and was supported by a deputy manager and a clinical lead. Staff told us they were well supported by their line manager. We found the management team to be very organised and knowledgeable. We felt they were making genuine efforts to improve the quality of care. During and following the inspection we requested information and this was provided promptly.

We spoke with relatives about whether they considered the service well led. One relative said "The manager is very positive and well organised. Her door is always open. She's a very nice lady." "I find it difficult to think of anything that could be improved in the home." This relative told us they had recently completed a satisfaction survey. Other relatives told us that the manager was not always visible in the service and if they had concerns they had to find her. They were aware there was an open door policy at the home but felt the manager was more, 'hands on.' Some staff said the manager was not always visible. When we told the manager about this they told us they held eleven o'clock meeting of all senior staff every day, they also did audits and walked round the service, they held resident/ relatives meetings and held surgeries where staff or relatives could drop in and discuss any issues they were concerned about. These were held on a weekly basis - on Wednesday for colleagues and on Tuesdays for relatives, with more formal meetings arranged for relatives every couple of months. They said they made themselves available for anyone wishing to speak with them. They told us they had an open door policy and said in future would ensure they were on the floor more often.

The manager said that they had recently introduced the role of senior carer. Staff who had been promoted would gradually take on an extended role and act as champions. For example one senior carer was taking on the role of monitoring the standards of infection control within the home.

The service had a quality assurance system in place which meant they asked people who used the service and their relatives what they thought about the quality of the service they received and how if at all it could be improved. Surveys were completed twice a year. The resident survey was being undertaken and due for completion in October and the relative satisfaction survey was completed in June 2015. The home responded by formulating an action plan focusing on all areas. The areas of improvement were actioned and completed. This meant the service was responsive.

The manager provided us with external audits completed by the NHS and audits completed by their regional manager who visits monthly.

The manager provided us with clear audits of falls, incidents and accidents showing clearly what actions had taken place as a result and what future learning has been adopted to try and reduce the likelihood of it happening again. So for example a fall might have resulted in a review of the risk assessment a referral to another agency to rule out an infection or a review medication which might make a person more prone to falls.

Relative and colleague surgeries were advertised around the home which gave people and their relatives the opportunity to formally discuss any aspect of the service. This was in addition to relatives meetings and one to one reviews of care.

The manager told us they were registered with FANS, (Fans is a scheme run by the Local Authority and stands for Friends and neighbours Scheme) and the idea is to engage with the wider community and identify how volunteers could support people living in the home, either by directly volunteering or by donations. The service was also registered with Dementia Friends which was launched by the Alzheimer's association and it aim was to increase awareness of dementia and provide support, training and information.

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
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider did not always ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons must be employed.** **Regulation 18 (1**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person did not ensure that all staff have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.** **Regulation 19 1(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Staff were not always documenting adequately how much people were eating and drinking and if it was sufficient to their needs. We were not assured people were adequately supported with their nutritional needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

People's records did not clearly indicate how they would like to receive their care and there was insufficient detail about individual choices and preferences.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.