Interhaze Limited

Sebright House Care Home

Inspection report

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Date of inspection visit:
09 August 2016

Date of publication:
19 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 August 2016 and was unannounced.

Sebright House is a nursing home providing care and accommodation for up to a maximum of 40 people. On the day of our inspection there were 39 people living in the home. Eight of those people were living in the home on a 'discharge to assess' basis. Those people would be in the home for a six week period prior to discharge to a more suitable place of care. Most people living in the home have complex dementia care needs.

People's bedrooms are situated on the ground and first floor of the building. There are three communal lounge areas and large conservatory.

This service was last inspected on 7 January 2015 and we found one breach in the legal requirements and regulations associated with the Health and Social Care Act 2008. A breach was found because people who had their liberty deprived had not been appropriately assessed to determine whether the restriction was lawful under the Deprivation of Liberty Safeguards. At this inspection we looked to see if the provider had responded to make the required improvements in the standard of care to meet the regulations. We found they had and they were no longer in breach of the regulations.

This service had a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run.

There were sufficient numbers of staff to provide the individual support people needed, and to manage the requirements of people with complex needs living together as a group. Staff were observant of people and communicated well to intervene and distract people when they became anxious, distressed or frustrated. Staff worked as a team to ensure people's safety and promote their emotional well-being.

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff knew about risks to people's health and wellbeing and followed plans to reduce those risks. Risk management did not impact on people's wishes and choices.

People's medicines were managed safely and only administered by qualified nurses or staff who had been trained and assessed as competent to do so. Staff followed best practice when giving people their medicines.

The registered manager and staff worked within the principles of the Mental Capacity Act 2005. They encouraged people to make as many of their own decisions as possible about their care and treatment, and understood the need to gain people's consent before providing care and support. Where deprivations on

people's liberty had been identified, the appropriate authorisations had been submitted to the local authority.

Care staff received training which enabled them to confidently carry out their roles and nurses received on-going training to maintain and develop their clinical skills. Staff felt supported in their roles and said they received regular support and guidance. Staff were given opportunities to develop their careers and gain further qualifications to support their development.

Staff were kind, caring and respectful when they engaged with people. Staff knew people well, they had a good understanding of people's needs and were aware of changes in people's moods and behaviour that could indicate they may be unwell or upset. Staff provided verbal and physical reassurance to people when they became upset or distressed. Staff worked together to develop strategies to promote people's health and wellbeing. Care plans were well structured and presented with easily accessible information. Plans were detailed and promoted personalised care.

There was a programme of activities which was displayed in the entrance to the home. However, the registered manager had identified that further work needed to be done to improve the range of activities provided and give more one to one time for people who were unable or chose not to engage as part of a group.

The registered manager and deputy manager both demonstrated a detailed understanding of the people who lived in the home and their individual mental and physical health needs. Staff had regular meetings where they talked about the service and information was shared. The registered manager valued staff and acknowledged their commitment to providing good quality care at the meetings.

The registered manager followed a monthly audit schedule to check that people received the care they needed. These checks had not identified some maintenance issues that needed to be addressed to ensure people's well-being and safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to provide the required level of support each person needed to keep them safe. Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. Recruitment and selection processes were in place to ensure, as far as possible, people were cared for by staff who were of good character. The policy for managing risks included assessments of people's individual risks to their emotional, physical and mental wellbeing. People's medicines were managed safely and only administered by qualified nurses or staff who had been trained and assessed as competent to do so.

Is the service effective?

Good

The service was effective.

People received care from staff who had the skills and knowledge to meet their needs effectively. The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005. Staff followed the principles of the Act and encouraged people to make as many decisions as possible about their care and treatment. People's nutritional needs were assessed and staff supported people to keep healthy and well.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and respectful when they engaged with people. Staff were quick to provide verbal and physical reassurance to people when they became upset or distressed. Staff demonstrated patience and tolerance and gave encouragement when supporting people.

Is the service responsive?

Good

The service was responsive.

The care plans were well structured, detailed and promoted personalised care. Care plans were regularly reviewed and updated when people's risks and needs changed. Staff knew about the people they supported and had the information they needed to respond to changes in people's health and care needs. Staff worked together to develop strategies to promote people's health and wellbeing.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management team had a good understanding of the people who lived in the home and their individual mental and physical health needs. The registered manager was open about the challenges the home had faced since our last inspection visit and the actions they had taken to meet those challenges. Staff felt supported in their roles and understood their responsibilities. The registered manager valued the staff team and acknowledged their role in providing good quality care. The registered manager followed a monthly audit schedule to check that people received the care they needed. These checks had not identified some maintenance issues that needed to be addressed to ensure people's well-being and safety.

Sebright House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 August 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with experience of nursing people living with a diagnosis of dementia and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before our inspection visit we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found that overall the information in the PIR was an accurate assessment of how the service operated.

We reviewed other information we held about the service. We looked at information received from relatives and other statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local authority commissioners responsible for contracting or monitoring people's care at the home. The local authority did not provide us with any information that we were not already aware of.

To help us understand people's experiences of the service we spent time during the visit observing people in the communal lounge and dining areas. This was to see how people spent their time, how staff involved people and how staff provided care and support to people when required. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who lived at the home to get their experiences of what it was like living at Sebright House and three visiting relatives. We also spoke with the registered manager, the deputy manager, one nurse, four care staff and a cook. We spoke with three visiting healthcare professionals, attended a multi-

disciplinary meeting with the healthcare professionals and observed a staff meeting.

We looked at four people's care records and six people's medicines records. We looked at other records including quality assurance checks, complaints, incident and accident records, three staff files and safeguarding records.

Good

Is the service safe?

Our findings

People who lived at Sebright had nursing needs with many having a diagnosis of advanced dementia. This meant they could not respond in detail to the questions we asked about their care. Relatives we spoke with expressed no concerns about the safety of their family members and the care they received in the home. One relative told us, "There seems to be a lot of staff around and they seem to be very attentive, caring and gentle."

Some people living at Sebright could become anxious and demonstrate signs of distress. Some could become frustrated and their frustration could sometimes escalate into physical behaviours. There were sufficient numbers of staff to provide the individual support people needed, and to manage the needs of people with complex requirements living together as a group.

Due to their physical and dementia care needs, some people required one to one or two to one support from staff. There were enough staff to provide the required level of support each person needed to keep them safe.

We found there was a constant staff presence in communal areas. Staff were observant of people and communicated well to intervene and distract people when they became anxious, distressed or frustrated. They were aware of where people were and their emotional presentation. Where people were in a low mood, we observed staff placing themselves between them and other people and gently moving people away to prevent any negative reactions or behaviours. Staff worked as a team to ensure people's safety and promote their emotional well-being.

The registered manager told us they worked with staff to ensure staffing levels consistently reflected people's needs which could fluctuate daily. They explained, "I am in touch with staff. If I see staff struggling, I will put extra staff on if I need to. I look at my residents' needs. We need to make sure we are properly staffed to look after our residents." Staff confirmed there were enough staff to enable them to meet people's needs without rushing. One staff member told us, "I always feel we have an adequate amount (of staff). I don't feel pressured or that I can't manage."

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff understood that safeguarding people from all forms of abuse was an important part of their role. They said regular safeguarding training helped them to be competent in understanding how to keep people safe. As some people had very limited communication, staff told us they were vigilant for non-verbal signs that people were worried or at risk of harm. One staff member told us they would be aware if, "They became withdrawn or extrovert, not their normal character – frightened, tearful or aggressive." All staff said they would report any concerns to the registered manager or other senior staff. During training staff were given information about who they could contact both internally and externally if they felt their concerns were not being taken seriously.

The registered manager had a good understanding of their obligation to report concerns to the local

authority safeguarding team and to ourselves. This demonstrated that the provider worked with other organisations to ensure people were kept safe from harm or abuse.

Recruitment and selection processes were in place to ensure, as far as possible, people were cared for by staff who were of good character. We looked at three staff files and found checks had been undertaken before staff began working at the home. These included written references and satisfactory Disclosure and Barring Service (DBS) checks. DBS checks whether a person has a criminal record and should take place before the person starts work. This helps an employer make a safe decision in appointing staff to ensure they are suitable to work with people who lived at the home.

The provider's policy for managing risks included assessments of people's individual risks. In the four care plans we looked at, risks to people's health, physical and emotional wellbeing had been assessed. Where risks were identified, people's care plans described how staff should minimise those risks. For example, where risks had been identified to people's mobility the care plans described the equipment needed and the actions staff should take to support those people safely. During our visit we observed staff used the appropriate equipment when supporting people to transfer or when mobilising. Pressure relieving cushions were in place for people who were at risk of skin damage. One person who was at risk of falling when in bed had a low profile bed with a crash mat to ensure their safety and minimise any injuries should they fall.

The registered manager told us that it was important that risk management did not impact on people's wishes and choices. They told us of one person who was at very high risk of falls but who enjoyed walking around the home and gardens. They explained, "[Person] is time limited now and does not want to spend the rest of their life sitting in a chair. You have got to assess the quality of life. If it improves their quality of life, we have the staffing levels to keep them safe. People will fall, but is that a reason to stop them mobilising if they want to?" This person had two to one staff support to allow them the freedom to walk as they wished. This promoted their emotional well-being but meant risks to their physical health were managed as safely as possible.

Staff were knowledgeable about risks to people's health and wellbeing and managed risks while still giving people choice. One person with swollen legs needed to have them elevated but constantly refused. We saw they refused to have their legs raised during our visit, but the care staff overcame this by elevating the person's feet when they fell asleep. Staff were aware of the need to share any concerns they had about risks to people's health. At the staff meeting held on the day of our visit, one staff member raised a concern about a person's room being limited in space to use the hoist safely. This was shared with the registered manager who told us they were aware of the issue and would take appropriate action.

Personal emergency evacuation plans had been prepared for each person which detailed the support they would require if they needed to be evacuated from the building. The plans were kept centrally which meant they were easily accessible by staff and emergency services to ensure people were moved quickly to a place of safety.

People's medicines were managed safely and only administered by qualified nurses or staff who had been trained and assessed as competent to do so. The registered manager explained, "I had a full days training on medicines administration, not only for my nurses but for the agency nurses who support us because I think it is important they are working in the same way we are."

Medicines were kept securely in a locked room and temperature checks were carried out to ensure they were kept at the correct temperature so they remained effective. Medicines that required stricter controls were managed in accordance with legal requirements.

We observed a member of staff giving people their medicines. They followed best practice and only signed the medicine administration record (MAR) once they observed people had taken their medicines. Handwritten amendments to the MAR were signed by two staff members to confirm their accuracy. MARs were complete and up-to-date and showed people were receiving their medicines when they needed them.

Some people were prescribed medicines for pain but were unable to communicate when they were in pain. The provider used individual pain assessment charts which informed staff how to identify when people required their pain relief. This involved recognition of pain through facial expression and body language along with increased behaviours or agitation.

Where it was necessary for people to be given medicine covertly (in disguise), this was agreed with the GP. Records showed one person had consistently refused to take their medicines. They had been referred to the GP to advise whether their medicines should be given covertly. The GP had assessed the risks of the person not taking their medicine and it had been agreed they could be discontinued. This showed reviews of people's medicines was carried out so they only received medicines they required.

Good

Is the service effective?

Our findings

People received care from staff who had the skills and knowledge to meet their needs effectively. Even though most people were not able to communicate verbally, we saw staff understood and anticipated their needs. One person told us, "The staff are very good" and a relative said, "They have a good understanding of dementia …..[Person] is well looked after." A visiting healthcare professional told us, "The care at Sebright is amazing. The carers are exceptional."

At our last inspection in January 2015, we found a breach of the regulations because the provider had not always identified when there were deprivations of people's liberty. They had not acted appropriately to ensure that people were not subject to unauthorised deprivations on how they lived their lives.

At this inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we found the registered manager understood their responsibility to comply with the requirements of the Act. When completing the Provider Information Return (PIR) they recorded, 'In response to our last CQC inspection I have ensured that all residents have had applications for DoLS made and staff training has been given to staff reinforcing mental capacity. The nurses have had further discussion ensuring that this is being complied with; using the mental capacity tool in each resident's care plan they now understand the difference between restriction, freedom and deprivation.'

We found senior staff assessed people's level of understanding and ability to consent to the care and support they needed. Where people had been assessed as not having capacity to make specific decisions for themselves, it was clear when and how staff should act in their best interests. For example, fortifying food for people who were not eating enough, but who did not have the capacity to understand the risks to their health of a poor diet.

We found staff followed the principles of the Act when providing people with support and encouraged people to make as many of their own decisions as possible about their care and treatment. Staff understood the need to gain people's consent before providing care and support and this was also reflected in care plans. For example, one person's mobility care plan stated, "Staff to gain consent and trust before any intervention. Fully communicate proposed moves." We asked one member of staff what they would do if a person refused personal care such as a shower. They responded, "It is knowing the resident. If [person] was adamant he didn't want a shower. We would try different carers or go back later. At the end of the day he

could always have a shower on Wednesday, unless he was covered in faeces and then it would be best interests."

Where deprivations on people's liberty had been identified, the appropriate authorisations had been submitted to the local authority. For example, such as where people had been assessed as being under constant supervision or they were prevented from leaving the home.

Staff received training which enabled them to confidently carry out their roles and responsibilities. Staff completed training which gave them the basic skills to care for people safely such as manual handling, fire safety, health and safety and infection control. During our visit we observed staff putting their training into practice such as when assisting people to stand or transfer with mobility aids.

The registered manager explained it was essential staff also received training in caring for people living with a dementia and managing behaviours that could be challenging, to support them in meeting the specific needs of people who lived at Sebright. "Staff need to know the signs so they can support the residents before they become more challenging." Most staff had completed this training and the provider had recently introduced MAPA (management of actual or potential aggression) training. This is training that teaches management and intervention techniques to cope with escalating behaviour in a safe manner. The registered manager told us she believed this training would benefit the people living in the home because, "I think it just gives staff a bit more confidence in situations and makes them a little more aware. It gives confidence and focus."

Nurses received on-going training to maintain and develop their clinical skills in areas such as catheterisation, syringe driver management and early detection of deterioration. Care staff were supported to gain further qualifications in health and social care to further develop their skills. Some staff had already obtained a National Vocational Qualification (NVQ) 2 in care and were completing their NVQ 3. Some staff were working towards their Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment.

New staff told us they had an induction which involved working with experienced staff when they started working at the home. Two staff spoken with felt the induction could have been more comprehensive, but felt the training that followed the induction was sufficient for them to carry out their role. One staff member told us, "I was classed as a 'shadower'. I was working alongside two other people. I was shadowing for about a week to a week and a half. I did request more time to shadow and it was granted. They were fine for that to happen."

People's nutritional needs were assessed and when people were at risk, strategies were written into their care plans such as providing fortified food or a pureed diet. However, we found that some of the information the cook had in the kitchen did not always accurately reflect what was recorded in people's care plans. For example, one person was identified as being at high risk of poor nutrition, but the list in the kitchen recorded them as being at low risk and there was no evidence their food was being fortified. We raised this with the registered manager who told us they had spoken with the cook about providing high calorie shakes for the person. They assured us that the information in the kitchen would be updated to reflect this. Records showed that the person's weight was monitored on a weekly basis and in the last six weeks they had gained weight.

Some people had fluid charts completed because they were at risk of not taking sufficient fluids. We looked at a selection of charts and saw there was no indication of how much fluid people required and staff were not totalling up how much people had consumed to identify when they had not been drinking enough.

Whilst the registered manager accepted the charts needed to be completed more accurately, they told us that staff shared any concerns about people's nutritional needs through 'caution and concern sheets'. We looked at a selection of these sheets and saw that staff had recorded when people had not been eating and drinking enough so staff coming on duty could encourage them to eat and drink more.

The main meal was served at lunch time and people had a choice of two options. They were shown both of the meals so they could choose which one they wanted. During the day we saw people being offered hot and cold drinks. One person was in the garden. We saw a member of staff brought them a hot drink at mid-morning demonstrating that staff were aware of where people were and made sure they had enough to drink.

Staff supported people to keep healthy and well. Regular health checks were carried out by staff and documented in people's individual records. For example, people's weights were monitored to check for weight loss or gain that could be detrimental to their overall health and wellbeing. People also received regular checks from other healthcare professionals such as the optician, dentist and chiropodist.

Staff were aware of changes in people's moods and behaviour that could indicate they may be unwell. Records showed if there was a change in people's health, they received the care and support they needed from appropriate healthcare professionals such as the GP. One person had recently been referred to the speech and language team because they were experiencing swallowing difficulties on a normal diet. People were also referred to other healthcare professionals if it was felt their input could improve people's everyday lives. For example, one person had been referred to a hearing specialist as it was felt that if their hearing improved, it would improve the quality of their life.

Good

Is the service caring?

Our findings

People who visited the home were complimentary about the care their relatives received. Comments included: "They are very caring," and "They are wonderful, very helpful." One relative told us the professional carers who used to look after their family member when they lived at home had recently visited them at Sebright. They said, "They came to see [person] last week and they told me the care was good here. There were a good number of staff around and they were actually doing their job; caring."

The Provider Information Return told us, 'Our staff create a homely, welcoming, supportive, inclusive atmosphere which means that our clients really do feel like they are 'at home'……..We specialise in higher level dementia care with challenging behaviours and our home is built on respect, trust and caring. We are extremely good at reducing challenges due to the skill of our staff and the affection, compassion and support that our clients receive whilst with us." During our visit we found there was a calm and happy atmosphere in the communal areas. Even though staff were busy, they took opportunities to acknowledge and chat with people as they moved around the home carrying out their care tasks. Staff were kind, caring and respectful when they engaged with people. We heard one member of staff say to a person as they walked through the lounge, "Wow you look beautiful." A recent compliment received by the home read, "What I want to say here is that I'm deeply impressed by how [staff member] responds to Mum, not just today but in the past. Such a charming, attentive, caring person that is always a pleasure to meet."

Care plans were written in a way that reinforced people should be treated with care and in a dignified manner. For example, one person's care plan read, "Staff to ensure [person] is treated with privacy, dignity and respect." We saw staff followed the care plans by encouraging people to make choices and respecting the choices people made.

We saw staff communicating with people and laughing with them. Where people had limited communication, we saw staff using facial gestures and body language to interact with them. One relative told us, "There are not many of them (staff) standing around doing nothing. They are here to engage with the residents and that's what they do."

"About me" life history information had been gathered about people at the home so staff could use the information when engaging with them and focus on the person rather than their diagnosis. Staff had a good understanding of people's needs and their behaviours. They approached people in a calm and respectful way.

Staff were quick to provide verbal and physical reassurance to people when they became upset or distressed. We saw one person became upset and tearful because they wanted to speak to a family member. The registered manager promptly brought out a telephone and asked the person if they would like to speak with them on the phone. The person nodded and they were put in touch with their relative straightaway which calmed their anxieties.

Staff demonstrated patience and tolerance and gave encouragement when supporting people. They

provided support at people's own pace and did not rush them. For example, we saw a member of care staff supporting a person to eat independently despite the fact they did this slowly. At one point the member of staff offered to assist the person, but the person was clear they wanted to do it themselves. The staff member respected this decision and disregarded the need for the person to wear a clothes protector as this would have disrupted the person's attempt to be independent.

Staff said they enjoyed working at the home and valued the opportunity to care for people with complex needs. One staff member told us about their first visit to the home and said, "When I came it was the buzz and people chit chatting. Staff greet everybody, it is a lovely atmosphere."

Relatives told us they felt welcomed and involved in their family member's lives within the home. One relative told us, "They always look after you when you come to visit." The registered manager explained that some people had younger relatives who visited. They told us they realised the environment could sometimes be challenging for some children to understand and supported them to have visits in quieter areas of the home. One relative had written to compliment the registered manager stating, "As a family going through a very difficult time, you have shown us all great support and compassion and for that we thank you."

Good

Is the service responsive?

Our findings

Relatives told us that the care people received was responsive to their family member's individual needs. Before people moved to the home, senior staff carried out an assessment of their needs to ensure the home was suitable for them. These assessments were often done in hospital, especially for people being admitted to the home on a 'discharge to assess' basis.

The PIR told us, "Our care plans are tailored to our individual residents with family involvement in a wholly person centred way and showing their preferences including such things as whether they prefer male or female carers and their preferred time of waking." We looked at the care plans for four people. The care plans were well structured and presented with easily accessible information. We found they were detailed and promoted personalised care. They provided information which helped staff to anticipate and respond to the needs of people with limited verbal communication.

Care plans were in place for specific health needs. For example, one person had a care plan for management of a small wound. There was documentation of daily dressings being applied and the condition of the wound at each application. This meant nursing staff had the information they needed to enable them to respond to any deterioration or changes in the presentation of the wound. We saw details of the summary of care for a person with diabetes along with a flow chart clearly outlining how high and low blood sugar levels should be managed. Risks had been identified along with management of the condition. Care plans were regularly reviewed and updated when people's risks and needs changed.

Staff knew about the people they supported. We spoke with two members of staff about the needs of a person whose care plan we had looked at. They demonstrated a good understanding of the person's needs and the risks associated with their care. Staff were very observant of people and because they knew people well, they picked up when things were not quite right. For example, one staff member was able to explain how a person changed when they had a urinary infection.

Staff told us they had the information they needed to respond to changes in people's health because they had regular handover meetings. One staff member told us, "We have handover meetings every morning and every afternoon. I feel it is very good and they (managers) talk to us and we can talk to them." Staff were also given a handover sheet detailing changes to ensure the responses to any changes was consistent. Staff also found it helpful that communication between nurses and care staff was good. One staff member told us, "You can go to them (nurses) at any time, whether it is a patient problem or personal." Another said, "I always feel confident the nurses would know what to do. They jump in and help as well. If we need an extra pair of hands they will come and help."

The registered manager had recently introduced weekly care meetings for the care staff. During the meeting people's nutritional needs, psychological responses and triggers for challenging behaviour and management of those behaviours was discussed. We attended the meeting and it was clear staff understood the need to pick up on things to bring to the meeting. For example, one member of staff had noticed that one person was more likely to be compliant with a particular member of staff. Another had noticed that one

person could become irritated with another person because they were very vocal. Staff worked together to develop strategies to promote people's health and wellbeing.

There was a programme of activities which was displayed in the entrance to the home. The activity co-ordinator arrived during the afternoon of our visit. They actively engaged people in ball games, construction toys and music and dance. We saw her laughing and dancing with people who wanted to and they showed visible enjoyment. One relative confirmed, "They play old CDs. There is a lot of music and they dance with them when the music is on." Records showed there were some organised trips out such as visits to the local park and local pubs and visits by entertainers and exercises with 'progressive mobility'.

The registered manager told us that activities were planned and based on what they knew people enjoyed. However, we found that some of the information about people's interests and hobbies was not always used. For example, one person liked particular newspapers and television programmes but we could not be sure they were supported to access these. Also due to their needs, a number of people were unable to participate in group activities or had a limited concentration span. The registered manager had recently completed an activities audit and identified that not all activities were appropriate for many of the people living in the home and that many people did not have the opportunities for one to one activities. The registered manager told us they were working with the activities co-ordinator to improve the range of activities provided and assured us people's views would be taken into account. They were also looking to appoint another activities co-ordinator to support the development of the service in this area.

Information that told people how and who to complain to was displayed in the communal reception area. Relatives were also reminded about how they could share any concerns at 'relatives meetings'. We looked at how written complaints were managed by the service. The registered manager said they had only received one formal complaint in the last 12 months. This related to a domestic issue and appropriate action had been taken by the registered manager and shared with the complainant. The registered manager said the complaint had been resolved to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the home were unable to share their views as to whether the home was well managed. However, relatives we spoke with were happy with the quality of care their family members received.

There was a management team in place. The registered manager was supported by a deputy manager who had been in post for two months at the time of our inspection visit.

At our last visit in January 2015 we found that the registered manager was not always fulfilling their legal responsibility to notify us of all the safeguarding incidents in the home as required. This meant we did not receive information to help us assess whether further action needed to be taken. At this visit we were assured that the registered manager was fulfilling their legal responsibility to notify us of any significant events within the service.

The registered manager and deputy manager both demonstrated a detailed understanding of the people who lived in the home and their individual mental and physical health needs. In the PIR the registered manager had recorded: "I am situated in an office next to one of the busiest areas of the home and my office door is always open, staff, families and residents are always welcome to come for a chat. I attend handover every morning with the full team of staff to ensure that I am completely up to date on a daily basis with everything that goes on in the home." Because of this the registered manager understood the fluctuating needs of individuals and the demands on staff supporting people with complex needs living together as a group. The registered manager's door was always open during our visit. When people entered the office, they were welcomed and not made to feel as if they needed to leave.

The registered manager was open about the challenges the home had faced since our last inspection visit. They explained they had lost some valued nursing staff due to changes in visa requirements. As a result they had reviewed the skill sets of staff and changed the staffing structure in the home. A new role had been introduced of 'healthcare practitioner' to work alongside and support the nurses. Staff had been promoted into these roles and had been trained to administer medicines. They were completing further nationally recognised qualifications at level five in health and social care to support them in their new roles. The registered manager told us the training and development of healthcare practitioners would ensure the service continued to be efficient and effective and people continued to receive a consistent level of care. They also told us the development of the role had enabled some people to advance their careers explaining, "Last time you were here there was no advancement, but there has been a real shift change. [Staff member] was a senior carer but now she looks after the 'discharge to assess' people which is a real advancement for her. There is progression here like there has never been progression in this home before. It is also knowing which staff want to move on and get higher so I spent a lot of time last week appraising staff."

Staff told us they felt supported in their roles and understood their responsibilities. Staff said they received regular support and guidance via supervision meetings where they discussed performance and personal development. Staff were positive when talking about the registered manager. One person told us, "She is really good. Her door is always open and she has always got five minutes for the staff. She is supportive and

encouraging." Another said, "There is nothing you can't go to her with."

Staff had regular meetings where they talked about the service and information was shared. One staff member told us, "If somebody has found a way to get round a particular problem, it is shared so others can try it." Staff told us they were invited to contribute to the meetings and felt their views were listened to. One staff member told us that the weekly care meetings had evolved from suggestions from staff.

Minutes of the staff meetings demonstrated that the registered manager valued the staff team. The registered manager passed on positive feedback they had received about the home and acknowledged the contribution of the staff team. The minutes of one meeting read, "Every role in this building is important and everyone is valued for the work that they do. I want all staff to feel valued in their roles and appreciated for the work they do. If you don't feel valued, if you feel that you need any support at all, I want you to come and see me."

To acknowledge staff for their commitment to providing good quality care, the registered manager had introduced staff days out to thank them for their efforts. A recent outing had been 'paintballing' and the registered manager explained, "It is important to get them (staff) out and having some fun." They had also introduced a 'Star of the month' award for staff. Staff were nominated by families and other staff and received a certificate and a personalised gift. Recipients of the award were displayed in the entrance to the home.

People's relatives were asked for their views of the service through meetings and surveys. In the surveys they were asked their opinion about the quality of care, the staff and whether they thought the home was interested in improving. The results of the last survey in 2015 indicated that relatives were happy with the service provided and gave positive responses to the questions asked. The registered manager told us they were currently sending surveys out for 2016. They had put notices up to remind people to complete the surveys as their opinions were valuable to maintaining and improving the quality of the service.

The registered manager followed a monthly audit schedule to check that people received the care they needed and to minimise risks to health and safety.

During our last inspection we found areas of the home that required maintenance or refurbishment. At this inspection we found a number of improvements had been made including the redecoration of some bedrooms and the installation of a new shower room. Communal areas such as the conservatory, dining room and the lounges had been redecorated to present a more homely environment. A room had been constructed in the garden which was described as a multifunctional room for meetings, staff training and a quiet area for families to spend time. However, we identified five bedrooms and a downstairs shower room where refurbishment was required as a matter of urgency. In one bedroom the carpet had been taped along the join and was fraying which presented as a risk hazard. The wall by the side of the bed was heavily stained. The skirting board had become sheared which had led to splintering of the wood which could have caused injury if anyone fell against it. We brought this to the attention of the registered manager who took immediate action to make it safe. In another room we found the electrical control to operate the bed was not working properly. The wires in the control had been connected incorrectly so that when the button to raise the head of the bed was pressed, the foot of the bed raised instead. In a third bedroom we noted that a fan in the room was last Portable Appliance Tested in 2008. The shower room was dirty and had not been deep cleaned for some time. Systems and audit processes implemented had not been effective in ensuring areas needing more urgent attention were addressed. The registered manager accepted that further improvements were required and an action plan to address these issues had been delayed due to illness within the maintenance staff team.

Regular equipment checks were carried out by the maintenance person but we saw some of the chairs with wheels used to move people around the home were damaged. They were an infection control risk because the fabric was torn and they could not be cleaned effectively. These chairs were not included on the maintenance list that we saw. Three hoists we looked at were dirty and needed cleaning, but this had not been identified during the monthly hoist checks. A wheelchair in the corner of one bedroom had no footplates in place. Checks had not identified these issues which could present a risk to people's safety.

Whilst there had been some adaptations in the environment to support people living with dementia, we found these were limited. Signs helped to orientate people to where they were in the home, but there was little to interest and stimulate people and engage their attention. Objects to provide tactile stimulation to people as they moved around the home were limited. The registered manager acknowledged this was an area where further improvements could be made.