Westermain Limited

Scotch Dyke Residential Home

Inspection report

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Ferring
Worthing
West Sussex
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Tel: 01903242061

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 22 August 2016 and was unannounced.

Scotch Dyke is a residential care home providing accommodation, including respite care, for up to 25 people, a small minority of whom are living with dementia or diabetes and who may require support with their personal care needs. On the day of our inspection there were 23 people living at the home. The home is a large property situated in Ferring, West Sussex. It has a communal lounge and conservatory, dining room and well maintained gardens.

The management team consisted of a registered manager, a deputy manager and team leaders. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

There were effective systems in place for the storage and disposal of medicines and people told us that they were happy with the support they received. One person told us "If I take tablets the staff give them, I don't remember, they do". Another person told us "I can't remember things so it is important that they do it for me, they keep it in a locked cabinet in the hall, and they are trained". However, there were concerns regarding the administration and management of medicines. Observations raised concerns regarding staff's practice when dispensing and administering medicines. Staff did not adhere to the correct procedures when dispensing and administering medication, particularly controlled drugs. Some people had medicines that were prescribed on an 'as and when required' basis. There was insufficient guidance available for staff to ensure that people received their medicines consistently and when they were needed. Some medicines, such as liquid medicines and creams, have a limited shelf life. Observations showed that several medicines, which had a limited shelf life, had been opened and no dates had been recorded on the containers to inform staff of how long the medicines had been in use. Therefore people were at risk of receiving out of date medicines that may be less effective or cause them harm. The registered manager demonstrated good practice and enabled people, who were able, to administer their own medicines. However, there was a lack of risk assessments to ensure that the people, as well as others, were safe when people administered their own medicines. These was an area that required improvement.

The registered manager had demonstrated good practice by ensuring that people's end of life care wishes were discussed and documented. End of life care records for one person showed that the person had made the decision to not be resuscitated. However, the registered manager had not taken timely action to ensure that there was legal documentation in place to ensure the person's wishes could be respected. This was an area in need of improvement.

People's consent was gained and staff respected people's right to make decisions and be involved in their care. The registered manager was aware of the legal requirements with regards to ensuring people who lacked capacity had mental capacity assessments and that they were not deprived of their liberty unlawfully. However, had not ensured that these were in place for all people who lacked capacity. For

example, one person, who used bed rails and who lacked capacity to consent to their use, had not had their capacity assessed, nor had their legal representatives been involved in the decision making process to consent to their use. This is an area of practice in need of improvement.

People provided mixed feedback with regards to the provision of activities. Some people told us that they enjoyed talking with other people, reading and resting, whereas other people told us that they were unhappy with some of the activities that were provided as they were too child-like, and chose instead to not partake in them. One person told us "The activities are for little kids, who wants to throw things around, we keep ourselves busy or sleep". Another person told us "We did have bingo, I liked that, we don't do the activities, they are silly, but I am not worried, I read". A third person told us "The bingo and music events are good, but the other stuff is not for me, I don't want to throw rings on things". This is an area of practice in need of improvement.

The provider had recognised that the quality assurance processes needed to improve and had recently subscribed to an external organisation to improve the quality assurance systems that were in place. However, current quality assurance systems were not sufficient or frequent enough to enable the registered manager to have sufficient oversight and awareness of all of the systems and processes within the home. For example, there were no care plan audits conducted and therefore delays in the implementation and legal documentation in a person's care plan was not recognised or acted upon in a timely manner. This is an area of practice in need of further improvement.

There were sufficient numbers of staff to ensure that people's needs were met and that they received support promptly. When asked why they felt safe, one person told us "I feel very safe, I've got my buzzer that I can use if I need help and they come within a couple of minutes, there is plenty of staff about". Staff were suitably qualified, skilled and experienced to ensure that they understood people's needs and conditions. Essential training, as well as additional training to meet people's specific needs, had been undertaken. People told us that they felt comfortable with the support provided by staff. When asked if they thought staff had the relevant skills to meet their needs, one person told us "They seem to, they tell me they do training and they have the qualifications".

People's healthcare needs were met. People were able to have access to healthcare professionals and medicines when they were unwell and relevant referrals had been made to ensure people received appropriate support from external healthcare services. One person told us "I need medication, care staff give me my tablets, I see my own doctor, if I need new glasses the optician comes here, which is good, the dentist comes here as well, but if I need important treatment I have to go to the dentist, my daughter takes me".

People had a positive dining experience and had access to drinks and snacks, of their choice, throughout the day. People told us they were happy with the food, one person told us "The food is good I have no complaints, I have a sherry and crisps each day at this time, I have always liked a small drink, lunch is always a hot meal, supper soup and sandwiches, I don't get very hungry here". Another person told us "The food is good, I didn't particularly like meat before but it is really tender here, it is old fashioned food, pie, fish in sauce, salad, they make a mean omelette, or salad if you don 't want what's on offer".

Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People were complimentary about the caring nature of staff, one person told us "The manager is very nice, I like her, I like all the staff, and I talk to all of them". Another person told us "The staff are wonderful".

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager to take at the back of the full version of the report.

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 home was not consistently safe.

People received their medicines on time, these were dispensed by trained staff and there were safe systems in place for the storing and disposal of medicines. However, there were some concerns regarding the dispensing, administration and management of medicines.

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

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

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity but had not always worked in accordance with this.

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

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind, caring and compassionate. Positive relationships had been developed between people and staff.

People were involved in decisions that affected their lives and care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People provided mixed feedback on the provision of activities. There was a lack of meaningful activities for people to participate in.

Care was personalised and tailored to people's individual health needs and preferences. However, care plans sometimes lacked information about people's social and emotional needs. There was sometimes a lack of timely action to ensure people's wishes were legally documented to ensure they were met.

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

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Although there were plans to develop this, current quality assurance processes did not sufficiently monitor practice to ensure the delivery of high quality care and to drive improvement.

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

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

Scotch Dyke Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 22 August 2016 and was unannounced. The inspection team consisted of 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 home. Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 17 people, one relative, seven members of staff, three visiting healthcare professionals and the registered manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for six people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounge and dining area during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in October 2013 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People and healthcare professionals told us that the home was a safe place to live and that there were enough staff to meet people's needs. One person told us "We are all safe and cared for here, I need help and I get it, they are all good to me and know me". A visiting healthcare professional told us "I come here at different times of the day and there is usually lots of staff around, especially if someone is really poorly". However, despite these positive comments we found an area of practice that requires improvement.

Observations showed people being supported to take their medicines after having their lunch and drinks were available to enable people to take their medication comfortably. People told us that they were happy with the support that they received. One person told us "If I take tablets the staff give them, I don't remember, they do". People were assisted to take their medicines by staff that had undertaken the necessary training. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person wanted staff to place the tablets onto their hand so that they could independently put these into their mouth. People were asked if they were experiencing any pain, this complied with the provider's policy for the administration of 'as and when required' medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. Each person had a medicine administration record (MAR) which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. The MAR contained clear and detailed guidance for staff to follow with regards to the administering of certain medicines. For example, body maps were completed to inform staff of where to apply cream to a person's body. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Some medicines require closer regulation because of the harm that can be caused if they are not managed safely. However, observations of the administering of medicines, particularly in relation to these types of medicines, raised concerns over the competence of staff. Observations showed one member of staff dispensing medicines for one person. The member of staff demonstrated good practice when dispensing the person's medicines, which were in a pre-filled, sealed container, that clearly detailed the person's name and the medicines contained within it, they checked that the information on the person's medicines corresponded with the details recorded on the person's MAR. However, in addition to the medicines in the pre-filled, sealed container, the person was also prescribed another, more regulated, medication. Observations showed that the member of staff had retrieved the medication and the medicines record book from the locked cabinet and had stored the medicines in the pocket of the tabard that they were wearing whilst dispensing the medicines. The member of staff uncovered the pre-filled, sealed container and dispensed the required amount of the medicine into the container and then sealed this, they then, once again, stored the container of medicines in their tabard pocket.

Another member of staff was called to assist the original member of staff dispensing the medicines, who asked the member of staff to sign the medicines book and take the medicines to the person for them to take. The original member of staff then signed the MAR indicating that the person had taken their medicines. When the member of staff was asked what they would do if the person refused their medicines they

acknowledged that they should have only signed the MAR once the medicines had been observed to be administered. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care staff should follow the six R's when administering medication. These include – right resident, right medicine, right route, right dose, right time and a resident's right to refuse. 'Managing Medicines in Care Homes' recommends that care staff administering medication should make a record of administration as soon as possible and complete the administration and recording before moving onto the next person. Although the member of staff ensured that they completed the MAR before moving onto the next person, they were not working in accordance with this guidance when signing the MAR after dispensing the medicines and without observing the person taking them. By asking another member of staff to take the medicines, which contained more regulated medicines, to the person, there was a risk that the person would not take their medicines and that the medicines could potentially have been misused as there were not two members of staff present as advised in the providers' policy. When asked about the procedures that staff should follow when dispensing and administering regulated medicines, the registered manager confirmed that two members of staff should be present when these are dispensed and administered. The concerns regarding staff's competency, when administering medicines, was also raised with the registered manager, who stated that staff are observed by the management team when they first complete their training but are only reassessed as competent if there are ever any concerns regarding staff's competence.

The aforementioned guidance suggests that helping people to help look after and take their medicines themselves is important in enabling people to retain their independence. Care staff should assume people are able to look after and manage their own medicines when they move into a care home, unless indicated otherwise. The registered manager had acknowledged this and there were two people who administered their own medication. One of these people told us "I give myself my tablets, I do it without thinking each day, I keep them in my room in a drawer, and they don't need to help me". The guidance states that an individual risk assessment should be undertaken to determine the levels of support a person needs to manage their own medicines, this had not taken place. Records showed that there were no assessments in place and therefore risks were not recognised or managed appropriately to ensure the safety and well-being of the two people or others. Neither were there mechanisms in place to establish how many tablets or stocks of medicines there were in the person's possession, or to record what medication had been taken.

Some medicines were stored in a medicines fridge, the registered manager ensured good practice was followed by ensuring that the temperature of the fridge was regularly monitored and recorded. Medicines can be less effective or harmful if they are out of date. Some liquid medicines and creams have a limited shelf life once they are opened. Observations showed that the date of opening had not been recorded on some of these medicines. For example, eye drops for one person, which had a limited shelf life once opened, had not been marked with the date of opening. Observations showed containers of creams, which also had limited shelf lives, in people's rooms. These containers were not marked with the date of opening. This meant that people may have been given out of date medicine as there was no system to check that medicines were still in date.

People had been prescribed medicines that they could take as and when they required them. The NICE guidance states that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in peoples care plans. Although the provider's policy stated the importance of this, there were no guidelines for staff to follow in relation to 'as and when required' medicines. This was raised with the registered manager and staff who

explained that they knew people well and were able to ask them if they required any 'as and when required' medicines and our observations confirmed this. However, one person who was prescribed 'as and when required' CD medicines was unable to indicate to staff when they might require these medicines. Staff and the registered manager told us that they would be able to notice if there were changes in the person's condition and discuss this as a team and a decision would be made as to whether the person required their 'as and when required' medicines. Staff were not provided with clear guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way.

The registered manager did not have robust, safe processes for the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for the environment, as well as people's healthcare needs were in place and regularly reviewed. For example, each person's care plan had a number of risk assessments which were specific to their needs, such as skin integrity, hydration and nutrition, falls and mobility. The risk assessments identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. For example, the use of pressure relieving mattresses or moving and positioning equipment. Accidents and incidents had been recorded and monitored to ensure that actions were taken to minimise reoccurrence. For example, accident records showed that one person had experienced five falls within a four day period. The registered manager had recognised that this person was not usually assessed as being at a high risk of falls, they had contacted the person's GP, who had found that the person had a urinary tract infection (UTI). Antibiotics had been prescribed and the person's condition had improved and they were no longer experiencing falls.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure the building was maintained to a good standard. Regular checks in relation to fire safety had been undertaken and people's cognitive and mobility needs had been assessed, as they had a personal emergency evacuation plan which informed staff of how to support the person to evacuate the building in the event of a fire.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

There were sufficient staff to ensure that people were safe and cared for. People, staff and healthcare professionals told us there was sufficient staff on duty to meet people's needs and our observations confirmed this. People's individual needs were assessed and this was used to inform the staffing levels. Staff told us that these were increased if people were unwell or needed additional support, for example, if they were at the end of their life. People told us that when they required assistance staff responded in a timely manner and our observations confirmed this. One person told us "I feel very safe, I've got my buzzer that I can use if I need help and they come within a couple of minutes, there is plenty of staff about". Another person told us "I use the caller by my bed, but don't need to often, they check you anyway, and I know they are there if I need them".

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

enables staff to raises concerns about a wrongdoing in their workplace.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff with the relevant skills and experience to meet their needs. People and healthcare professionals confirmed that staff were competent, well trained and efficient. When asked about the experience and competence of staff, one person told us "They seem to, they tell me they do training and they have the qualification". A visiting healthcare professional told us "If you ask staff a question they always seem to know what you are asking or they can look it up in the records". However, despite these positive comments we found an area of practice that needs improvement.

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).

We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. This related to a person who was unable to leave the home on their own due to risks to their safety and well-being. The registered manager fully understood the requirements of this legislation and had acted in accordance with it, therefore ensuring that this person was not deprived of their liberty unlawfully. However, one person had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. When the registered manager was asked if the person had capacity and had consented to the use of bed rails they told us that the person would have consented at one time but now would not have the capacity to consent to their use. Records did not show that consent had been gained. Mental capacity assessments should be decision specific and assess a person's ability to understand the information related to the decision being made. The person should be able to retain and weigh up the information and communicate their decision. Records should show how the decision of capacity was reached. A mental capacity assessment for the use of bed rails had not been conducted. The person had legal power of attorneys (LPA), there was no documentation to show that the use of bed rails had been discussed with them and therefore neither the person, nor their legal representatives had consented to their use. This is an area of practice in need of improvement.

The registered manager had demonstrated good practice and had asked people their wishes with regards to their end of life care. End of life care records for one person showed that they had made the decision to not be resuscitated should the need arise. When the location of a DNACPR form (Do not attempt cardio-pulmonary resuscitation) was requested during the inspection we were advised that there was not a form in place. This was raised with the registered manager who explained that they had sent a form to the person's legal power of attorney (LPA) to request their consent, despite the person having capacity and stating their needs to the registered manager within the end of life care plan. The end of life care plan had been devised

three months prior to the inspection and a DNACPR form was still not in place. When the registered manager was asked about the delay in ensuring this form was completed and held on file they informed us that they had waited some time to receive a form from the person's LPA. When asked what would happen if the person needed to be resuscitated the registered manager explained that staff would have to resuscitate as there was no legal document in place to inform them otherwise. The delay in ensuring this decision was legally documented could have potentially meant that the person's wishes, with regards to not being resuscitated, would not have been respected as there was not the appropriate documentation in place.

There was a commitment to staff's learning and development. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction and this had been updated to reflect the introduction of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. In addition to this, staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs as well as to have an awareness of the expectations of their role.

Staff had completed essential training and updated this regularly. In addition to essential training staff had also completed training that was specific to the needs of the people they cared for. For example, staff had undertaken courses in diabetes awareness and dementia care. There were links with external organisations to provide additional learning and development for staff, such as the local authority and local colleges. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. Most staff held diplomas in health and social care. People were cared for by staff who had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

People's communication needs were assessed and met. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. Effective communication also continued amongst the staff team. Regular handover and team meetings, as well as daily written handover reports and communication books ensured that staff were provided with up to date information to enable them to carry out their roles.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians and district nurses. Visiting healthcare professionals told us that the home responded promptly to people's health needs. One healthcare professional told us "I've always been impressed by the care I've seen. There are very good senior staff, they're good at getting things organised. If you tell them someone may need to see their GP, they're on the phone arranging it straight away, nothing is put off". Staff told us that they knew people well and were able to recognise any changes in their behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us "I need medication, care staff give me my tablets, I see my own doctor, if I need new glasses the optician comes here, which is good, the dentist comes here as well, but if I need important treatment I have to go to the dentist, my daughter takes me".

People had access to sufficient quantities of food and drink. Observations showed that there were jugs of squash available for people to help themselves and staff offered people snacks, tea, coffee or glasses of sherry before their meal. People had a positive dining experience. People were happy with the environment

and the quality, quantity and choice of food available. Most people chose to eat their meals in the main dining area. This was well presented and created a pleasant environment for people to have their meals. Tables were laid with tablecloths, napkins, vases of flowers and condiments. People were able to sit with their friends and we observed people enjoying conversations with one another. One person told us "The food is good I have no complaints, I have a sherry and crisps each day at this time, I have always liked a small drink, lunch is always a hot meal, supper soup and sandwiches, I don't get very hungry here". Another person told us "The food is good, I didn't particularly like meat before but it is really tender here, it is old fashioned food, pie, fish in sauce, salad, they make a mean omelette, or salad if you don 't want what's on offer". People were asked for their feedback about the dining experience and the food choices available during monthly meetings with the management team.

Good

Is the service caring?

Our findings

People were cared for by staff that were kind, compassionate and caring. Observations demonstrated that positive, warm and affectionate relationships had developed between people and staff. People, relatives and healthcare professionals confirmed that staff were kind and caring. One person told us "I find them a nice bunch, there are plenty of them, they are a good age range, and I can't fault them, you have to be realistic, I wouldn't stay here if they didn't treat me well". Another person told us "I can't ask for anything more, they are good to me". A feedback form from a recent respite stay contained the following comment, 'I have stayed at Scotch Dyke several times for respite and given a choice I would not use any other home. Unfortunately it is so good it is often not able to accommodate me. I wish there was a respite room to book in advance. An excellent care home'.

People were cared for by staff that knew them and their needs well. It was apparent that positive relationships had been developed. There were warm, humorous and friendly interactions between people and staff and people told us that they liked the staff and were happy. One person told us "I do what I want, they make me laugh and I make them laugh, I pick flowers and say 'oops that bent and fell off' and they go along with it, they are around and talk to me". Healthcare professionals further praised the caring approach of staff. When asked about the caring nature of staff, one visiting healthcare professional told us "They're excellent, really, really good. Every member of staff I've met is good, very caring staff". Another visiting healthcare professional told us "I used to come here for one person, who could sometimes be quite rude to the staff. However, the staff were so good with them, they were always patient and kind, courteous and pleasant to them".

There was a friendly, warm and sociable atmosphere. People enjoyed interacting with one another and it was apparent that caring relationships had been developed between people as well as with staff. People were encouraged to maintain relationships with one another as well as with their family and friends. Observations showed people engaging in conversations with one another throughout the day. People told us that they were able to have visitors to the home and that they were welcomed and able to join them for lunches and our observations confirmed this. Results of a recent quality assurance survey sent to people's relatives, contained comments such as 'Visitors' are made to feel welcome at any time of day. I'm always offered refreshments'. The registered manager recognised the importance of people maintaining contact with their relatives, even when they lived far away. One person was supported to use technology to maintain contact with their relative who lived overseas. It is a technology system that enables people to have conversations or share video messages with one another over the internet. Some people had telephones in their rooms and told us that they could contact family and friends whenever they liked.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identify, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regards to people's religion and people were able to maintain their religion if they wanted to. Care plan records informed staff of people's religion and there was an in-house holy communion service offered every six weeks.

People were involved in their care. Records showed that people had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt fully involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. Observations showed that relatives were involved in their loved ones care. They were observed talking with staff about the care their relative had received. People had been asked if they would like to participate in regular resident meetings, however had chosen instead to meet individually once per month, with part of the management team, to discuss their needs and any concerns that they had. Records confirmed that people had spoken about their preferences with regards to how they spent their time, their food choices and health. When actions needed to be taken in response to the feedback from people, the registered manager had ensured that care plans were updated or changes made to accommodate people's views. For example, one person had commented about the food, the registered manager had recorded that they had spoken to the chef and communicated the person's opinions to them.

Observations confirmed that people were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect and that they took time to talk, explain information and listen to their needs. The registered manager had recognised that people might need additional support to be involved in their care; they had involved people's relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's privacy was respected. Information held about people was kept confidential, records were stored in locked cabinets and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People confirmed that they felt that staff respected their privacy and dignity. One person told us "I don't like to eat in front of other people which the staff know, so I get my meals in my room". Visiting healthcare professionals further confirmed that staff respected people's privacy and dignity. One healthcare professional told us "They treat people with great respect. They cover people with towels if they are assisting them with personal care and always knock on their doors". Observations demonstrated that staff respected people's right to privacy. For example, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. One member of staff was observed taking a telephone to one person and explained that their relative wanted to speak to them. The member of staff asked the person if they were happy to receive the telephone call in the communal lounge or if they wanted to go somewhere more private.

Independence was encouraged. Observations showed people independently walking around the home and gardens and choosing how they spent their time. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves and records and observations confirmed this. One person was supported by staff to walk from the lounge to the dining room using their mobility aid. Staff demonstrated patience and kindness and were observed offering encouragement and praise to the person as well as ensuring the person was comfortable and did not need their wheelchair. One person told us "They're excellent, couldn't do better, I get offered a wheelchair or if I want to walk, I choose". Another person told us "I can do what I want, when I want, I can go out but don't, as I fell, I felt faint so worry now, but I feel alright here, they look after me".

Requires Improvement

Is the service responsive?

Our findings

People were central to the care provided. People told us they were able to approach staff to discuss their preferences and changes in their needs and that staff listened to them. One person told us "I am not worried, I see the staff every day so I can talk to them". Another person told us "You can talk to senior staff and they speak to their line manager and we get what we want". However, despite these positive comments, we found areas of practice that require improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. People provided mixed feedback with regards to the activities and entertainment that was provided. Some people told us that they had enjoyed the external entertainers that sometimes visited the home and enjoyed reading or talking to one another. One person told us "We don't need entertaining I like to sleep a lot, I read the paper, talk to other people, we have had music and bingo that was good everyone enjoyed that". Another person told us "We don't need to do things we've spent our lives doing things, we all read, there is a good library, we sleep in the afternoons, we have a TV and watch whatever's on". However, there was a lack of meaningful activities for people who wished to participate in activities. The Alzheimer's Society states that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. People told us that they enjoyed some of the activities such as bingo and quizzes, however, felt that the other activities were too child-like. One person told us "I don't like the activities they are childish, so I read and sleep, I am okay with that". Another person told us "The activities are for little kids, who wants to throw things around, we keep ourselves busy or sleep". A third person told us "We don't do the activities, they are silly, but I am not worried, I read". Observations showed people spending their time sitting in their armchairs listening to music, reading or sleeping. There was a short game of quoits, however, people appeared not to be interested in taking part in this activity. Records showed the activities people had participated in, however, they lacked detail with regards to how engaged people had been and if it was something the person had enjoyed. Records for one person showed that the person had spent eleven days in August reading the newspaper in the morning and watching the television during the afternoon. Records for another person showed that they had spent fourteen days in August where no activity was undertaken during the morning. Records for a third person showed that having their sore legs soaked and having cream applied was recorded as an activity. The provision of activities and stimulation for people is an area of practice in need of improvement.

People told us that they were involved in decisions and were able to talk to staff if they ever had any concerns about their health or care needs. People's physical and health needs were assessed and met. People's needs had been assessed when they first moved into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities in relation to their care needs. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and the registered manager confirmed, that people and their relatives had been involved in the development of the care plans. Care plans were reviewed on a monthly basis, unless changes occurred before this time, by staff and these were based on observations of people's conditions and changes in their health needs throughout the month. These reviews took into consideration

changes in people's health needs and care was adapted accordingly. For example, records for one person showed that the person's health had deteriorated, a review took this into consideration and the person's risk assessments and care plans were changed accordingly. However, care plans did not always contain any person-specific information about people's lives before they moved into the home, their interests, hobbies or social and emotional needs. Information of this nature can help provide staff with an insight into people's lives before they moved into the home, can help to develop relationships and provide more of an understanding of people's holistic needs. When the lack of person-centred information was raised with the registered manager this was something that they felt could be developed further. This is an area of practice in need of improvement.

People were supported to make choices in their everyday life and their individuality was respected. Observations showed staff respecting people's wishes with regards to what time they wanted to get up, what clothes they wanted to wear, what they chose to do with their time, what they had to eat and drink and what they needed support with. People were also able to choose if they received support from male or female carers. People were happy with their rooms and told us that they were able to furnish them according to their tastes and our observations confirmed that they were furnished according to their preferences and individuality and they were able to display their own ornaments and photographs.

There was a complaints policy in place. Complaints that had been made had been dealt with appropriately and according to the provider's policy. The registered manager encouraged feedback from people and their relatives. There was a suggestion box for people and relatives to use. People told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager. One person told us "I haven't had any complaints, but would speak to the manager if I was worried, she would sort it out for me". Another person told us "I get help when I need it, I have been here a long time and they are good to me, so I don't have to worry, but if I did I would tell the senior person and expect them to get advice and come back to me".

Requires Improvement

Is the service well-led?

Our findings

People, staff and healthcare professionals were extremely complimentary about the leadership and management of the home. They told us that the management team were approachable, friendly and caring. One member of staff told us "The manager likes things done properly and to a very high standard but she is always there for support and advice". Another member of staff told us "The home is really well managed, there is an open door policy to the office and we can always go to the manager without feeling what we have to say will not be taken seriously". However despite these positive comments, we found an area of practice in need of improvement.

A range of quality assurance audits should take place within a home to ensure that the systems and processes used are effective, this also helps to identify areas of practice that need to improve and drives change. The registered manager undertook quality assurance processes every six months to measure and monitor the standard of the service provided. However, had recognised that these were not sufficient nor frequent enough to sufficiently monitor the systems and processes with the home. For example, the current quality assurance process did not undertake regular care plan audits and had failed to recognise that it had taken three months for the implementation of legal DNACPR documentation. Nor were there regular medication audits or competency checks carried out on staff, once they had completed their initial training and competency check, and therefore staff's practice was not monitored with regards to this and the registered manager had not identified the areas of concern that were observed as part of our inspection. The provider had recently subscribed to an external organisation to assist them to improve the quality assurance systems in place and had started to implement these in relation to surveys to gain people's, relative's and staff's feedback. However, despite the proposed new quality assurance systems these were not embedded in practice and the current quality assurance processes were not sufficient to ensure that the home was effective nor did they enable the registered manager to have a sufficient oversight to ensure that people were receiving the quality of service they had a right to expect. Therefore this is an area of practice in need of further improvement.

The management team consisted of the registered manager, a deputy manager and team leaders. The provider had a philosophy of care that stated 'We believe in a philosophy of care and compassion, based around our residents. Everyone at Scotch Dyke is an active participant in that philosophy and the proprietor, management and staff are committed to its implementation'. This was embedded in the culture and implemented in practice. There was a friendly, warm and homely atmosphere, people told us that they felt happy, content and at home. One person told us "I came here for two weeks respite, by the second day I asked if I could stay permanently, its lovely here". Results of a recent quality assurance survey sent to people's relatives, contained comments such as 'I find Scotch Dyke a very friendly and well-run care home'. Visiting healthcare professionals confirmed this, one healthcare professional told us "They're always around, if you ask them questions they always know the answers, they're clued up and understand what they do, if people need anything they get it".

There were links with some external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These

included links with the local authority and local colleges. The registered manager worked closely with external health care professionals such as the GP and district nurses to ensure that people's needs were met and that the staff team were following best practice guidance.

The manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The registered manager had signed up to the social care commitment. A Department of Health initiative that is the adult social care sector's promise to provide people who need care and support with high quality services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment The registered person had not taken the appropriate action to ensure the proper and safe management of medicines.