Bupa Care Homes (ANS) Limited

Warren Lodge Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection which took place on 14 and 15 October 2015. The service was last inspected on 15 October 2013 when we found it was meeting regulations.

This service provides accommodation and personal care for up to 64 people. People at the service are older people living with dementia, some of whom have limited mobility. There were 64 people living at the service at the time of our inspection. Accommodation is arranged over two floors and people had their own bedroom. Access to the first floor is gained by a lift, making all areas of the service accessible to people.

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

Summary of findings

People and their visitors commented positively about the care and support received and their experience at the service. However, the inspection highlighted some shortfalls where the regulations were not met. We also identified areas where improvement was required and made recommendations that the service should adopt.

Medicine was not always stored at the correct temperature and medicine, prescribed to be given to people as and when it was needed, was routinely given to people without evaluating the need or recording the reasons why.

Staff had not practiced fire evacuation drills and may not be familiar with what to do in an emergency. Some checks needed to ensure staff were suitable to work at the service were not recorded.

Some health care plans, intended to inform people's recovery and prevent deterioration, were not completed in accordance with instructions. This devalued the purpose of the health care plans because some required actions were not met.

Quality audits carried out by the registered manager and the provider were not fully effective because they had not provided continuous oversight of all aspects of the service. Authorisations made under the Mental Health Act 2005 to deprive people of their liberty were not notified to The Commission when they needed to be.

Services and equipment including the electrical installation, gas safety certificate, portable electrical appliances, fire alarm and firefighting equipment were checked when needed to help keep people safe. The service was well maintained and comfortable.

The registered manager and deputy manager had a good understanding of the Mental Capacity Act 2005, and Deprivation of Liberty safeguards. They understood in what circumstances a person may need to be referred, and when there was a need for best interest meetings to take place. We found the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and that people's rights were respected and upheld.

There were enough staff to meet people's needs. Staff understood how to protect people from the risk of abuse and the action they needed to take to alert managers or other stakeholders if necessary if they suspected abuse to ensure people were safe.

New staff underwent an induction programme and shadowed experienced staff, until they were competent to work on their own. There was a continuous staff training programme, which included courses relevant to the needs of people supported by the service. Most care staff had completed formal qualifications in health and social care or were in the process of studying for these.

There were low levels of incidents and accidents and these were managed appropriately by staff who sought appropriate action or intervention as needed to keep people safe. Risks were identified and strategies implemented to minimise the level of risk.

Care plans were reviewed regularly and included the views of the people and their relatives or advocates when needed. The service showed an awareness of people's changing needs and sought professional guidance, which was put into practice.

People were able to choose their food each meal time, snacks and drinks were always available. The food was home-cooked. People told us they enjoyed their meals, describing them as "excellent" and "first class".

The service was led by a registered manager who worked closely with the deputy manager, clinical manager and the staff team. Staff were fully informed about the ethos of the service and its vision and values. They recognised their individual roles as important and there was good team work throughout the inspection. Staff showed respect and valued one another as well as people living at the service.

We found four breaches: Three related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breached the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Some medicines were not stored appropriately and fire evacuation drills had not been practiced.

Recruitment checks were not effective because risk assessments required before employing some staff were incomplete.

Staff knew how to recognise abuse and accidents, incidents and risks were managed appropriately.

There were enough Registered Nurses and staff on duty.

Requires improvement

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

Some checks to monitor people's condition were not always carried out when they should have been to ensure people's well-being.

Charts to safeguard against the risk of dehydration did not contain sufficient information to readily ensure target amounts of fluid were known.

Staff were provided with opportunities to meet with their supervisor or manager to discuss their work performance, training and development.

New staff received a comprehensive induction and had access to a rolling programme of essential training. Staff were given specific training in the conditions some people lived with in the home.

The service was meeting the requirement of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Requires improvement

Is the service caring?
The service was caring.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People felt confident in raising concerns and action was taken to address issues raised.

Care plans reflected that people were able to express their views and be actively involved in making and reviewing decisions about their care.

Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions.

The home employed three activity coordinators and people told us they enjoyed the activities provided.

Is the service well-led?

Requires improvement

The home was not always well led.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

Statutory notifications required by CQC were not submitted.

The service had an ethos of continual development and improvement, by using published guidance about dementia care to enhance people's experience of living at the home.

Staff felt supported. They were aware of the service's values and behaviours and these were followed through into their practice.

People, their relatives and staff thought the service was well run and spoke positively about the leadership of the registered manager.

Warren Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons were 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.

We undertook an unannounced inspection of this service on 14 and 15 October 2015. The inspection team consisted of two inspectors and a specialist advisor who was experienced in nursing care.

Before our inspection we reviewed the information we held about the service. This included the Provider Information Return that we asked the registered persons to complete. This is a form that asks registered persons to give some key information about the service, what the service does well and improvements they plan to make. In addition, we reviewed notifications of incidents that the registered persons had sent us since the service was registered. These are events that the registered persons are required to tell us about. We also reviewed information from local commissioners of the service and healthcare professionals. This enabled us to obtain their views about how well the service was meeting people's needs.

We focused on speaking with people who lived in the service, speaking with staff and observing how people were cared for and their interactions with staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us.

During the inspection we spoke with 14 people who lived in the service and with four relatives. We also spoke with three nurses, a clinical lead, five care workers, a housekeeper, the chef, the registered and deputy managers as well as the regional quality, training and area managers. We observed care in communal areas and looked in detail at the care records for 12 people and looked at some aspects of care for five more people. We also pathway tracked some people living at the service. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the service including bedrooms, bathrooms, the lounge and dining areas as well as the kitchen and laundry area. In addition, we looked at records that related to how the service was managed including staffing, training and quality assurance documentation.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and were happy living at Warren Lodge Nursing Home. Comments included, "It's very pleasant here" and, "I feel well looked after, I haven't had any problems, there is nothing I feel concerned or worried about". A visitor we spoke with felt they were usually kept up to date with the care and support their relative received and told us, "I have every confidence in the home, its safety and the care provided". Another visitor commented, "This is the best home by far, I looked at a lot of homes before this one and I have no concerns about my relative living here". However we identified some areas of practice which meant that the service was not always safe.

We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. The temperature of the medication room had been monitored on a daily basis. However, records showed 16 occasions in July and two further occasions in August 2015 where recorded temperatures in the room had exceeded maximum acceptable limits (25 c). This presented a risk that medicine stored at an incorrect temperature may become desensitised and potentially ineffective. We brought this to the attention of the registered manager who gave an undertaking this issue would be addressed.

Medicines were not always suitably stored. This failure was in breach of Regulation 12 (2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about practices regarding the use and review of some medicines. This was in relation to the routine use of a medicine as night time sedation and the ongoing and regular use of one medication as a means of behaviour management. Medicine Administration Records (MAR) charts for two people showed these medicines were given on a regular and ongoing basis. Their plans for 'health and happier life' included one sentence in relation to this medication, 'to administer night time sedation'. The medicine was prescribed to be used as and when needed (PRN), however, behavioural analysis and the reasons why the medicines were administered was not always recorded. Therefore there had been little evaluation of the effectiveness and ongoing need for this medication.

We recommend the service review practices to ensure they conform to published guidance, such as the Royal Pharmaceutical Society for The Handling of Medicines in Social Care or The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes, in relation to the use, review and evaluation of PRN medicines.

Medicines held by the service were securely stored and people were supported to take the medicines they had been prescribed. We looked at people's MAR charts and found that all medicines had been signed to indicate that they had been given. Staff administering medicine attended appropriate training and were monitored regularly to ensure they were competent to manage medicines.

People were not protected as far as practicably possible by a safe recruitment system. Records showed employment histories were checked, suitable references obtained and Disclosure and Barring Service checks (DBS) were undertaken when staff were recruited. However, where DBS checks disclosed convictions, although considered by senior management, the decision and any associated risk assessment to employ such staff were not recorded. We discussed this with the registered manager who acted immediately to address this issue. However, as systems in place were found incomplete, this did not promote the principles of a robust recruitment process to protect the safety of people living at the service.

This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed services and equipment were checked when needed to help keep people safe. These included the electrical installation, gas safety certificate, portable electrical appliances, fire alarm and fire fighting equipment. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Service contracts ensured equipment to support people with their mobility such as the service's lift, standing aid hoists and bath facilities were safe and fit for purpose. Regular water temperature checks and thermostatic water mixing valves helped to safeguard against risks of scalding. Appropriate water management systems were in place to safeguard against the risks of legionella, a water borne bacteria. A

Requires improvement

Is the service safe?

Personal Emergency Evacuation Plan / personal safety plan had been prepared for each person and a business continuity plan and disaster recovery plan was in place and kept under review. However, it was not clear when or if fire evacuation drills had been practised. This was discussed with the registered manager who agreed a drill had not been completed recently. Providers must have and implement procedures to ensure the safety of their premises, including emergency procedures, to ensure staff are familiar with actions needed to keep people safe in the event of an emergency.

This failure was in breach of Regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was designed in conjunction with dementia experts, purpose built, clean, free from odours, well-furnished and recently decorated. People, visitors and staff commented positively about the layout and facilities, including en-suite wet rooms for each bedroom, a hair salon, cinema lounge, extensive seating, large dining areas and visitor/family rooms. A planner scheduled ongoing maintenance. Staff reported any repairs needed in a maintenance book, which showed these were acted upon quickly. Health and safety plans included weekly, monthly, six monthly and annual checks and audits of equipment, plant, systems of work and environmental standards. This covered the management of health and safety at work, fire risk assessment, compliance with standards and regulation, the building fabric and maintenance, grounds, landscaping and pathways. An Environmental Health food hygiene rating score of the kitchen had recently taken place, with the highest rating of five stars awarded.

There were sufficient staff to meet people's needs. Staffing comprised of two registered nurses per floor and six care staff in addition to clinical managers, the registered manager, activities staff and ancillary staff. Staff and visitors felt there were always enough care staff and registered nurses on duty and said the current registered manager had increased staffing levels. There was little use of agency staff, as most shortfalls were met through use of bank staff. This helped to ensure consistency of care.

Any concerns about people's safety or wellbeing were taken seriously. Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them about what to do. The service also held a copy of the locally agreed safeguarding protocols. Staff said in the first instance they would alert any concerns they might have to the registered manager, but understood about and could name the relevant agencies that could be contacted if their concerns were not acted upon. The staff room contained reference information, such as policies and procedures as well as the service's safeguarding and whistleblowing procedures.

Individual risk assessments were completed and reviewed when needed. Staff were knowledgeable about the people they supported and familiar with risk assessments. These included medication, eating, drinking and risks of skin damage as well as use of equipment such as pressure reducing mattresses, lifting aids and wheelchairs. Care plans included at a glance description of key safety risks for people, for example, how a person without verbal communication may express pain. There was a low occurrence of incidents and accidents, each was reviewed and audited by the clinical manger using a falls analysis tool. This enabled the service to look for any patterns or trends and to inform learning and care plan reviews. For example, following falls some people were referred to falls clinics and provided with hip guards and or bump hats. This helped to keep people safe by minimising the risk of incidents happening again and the risks of injury.

Requires improvement

Is the service effective?

Our findings

People and their relatives were positive about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "They look after me so well", "The staff are hardworking" and "All of the staff seem very able". People and their relatives said that staff communicated with them well. A visitor commented, "Staff are always welcoming, and are good at keeping me updated about how my relative is".

Although people commented positively, we found aspects of the service were not always effective. People did not benefit from best practice procedures to ensure some of their health needs were always monitored appropriately. For example, although comprehensive health care plans were in place for skin care, diabetes management and the monitoring of the condition of a person's legs, these required checks were not always carried out when the plans specified they should be. This did not meet the intended purpose of the plans and meant that some areas of people's care and support did not promote the best outcomes possible or allow for early intervention in the event that a person's condition deteriorated.

Practices did not follow planned care and treatment pathways. This is was in breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records showed evidence of regular health appointments and contacts with health professionals for example; diabetes and obesity clinics, GP's, dentists, chiropodists, occupational therapists and dieticians to ensure people's overall health and wellbeing were maintained. Records showed health professionals were contacted to give treatment as needed. Staff were familiar with medical advice about how to support people and we saw that advice received was put into practice, for example, the provision of softened meals or thickened drinks. Where people had specific communication difficulties, such as loss of hearing, staff showed awareness of these needs and used appropriate methods, for example, picture cards, to aid understanding. Where one person's first language was not English, the service employed staff able to speak their language. This helped to ensure effective communication and reduced the person's anxiety. People and, where possible, their relatives had been involved planning and agreeing care plans.

Food and fluid charts were retained in people's bedrooms. These were used where concerns were identified, typically loss of weight or a risk of malnutrition or dehydration. Those seen had regular entries. Nutrition assessments (Malnutrition Universal Screening Tool (MUST) were completed and reviewed each month. Weight was monitored, recorded and action taken to respond to any weight loss. Fluid charts had a running total of liquids consumed; however, they did not contain information relating to the expected fluid intake for that individual. Without such information, it was difficult to establish if the required amount was achieved. We have identified this as an area that requires improvement.

The lunch time meal was a well-managed and relaxed occasion. The menu was on display and in clear print; visual aid cards helped some people make choices about their food. The opportunity was taken to make this a social occasion for people. Several people ate their meals with visiting relatives. Eating aids, such as adapted cups, plates and cutlery had been provided to people who needed them to enable them to eat independently and in a dignified manner. Tables were laid and included serviettes, condiments and water. People could also have juice or hot drinks of choice. Sufficient staff supported people in the dining areas as well as people eating their meal in their own rooms. A member of staff was present to provide support to people who needed help to eat. Softened or fortified food and thickened drinks were provided where needed; staff were aware of the amount of thickener to put into drinks to ensure they were the right consistency. A 'Night bites' menu provided snacks for people outside of regular meal times.

Staff received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aim to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used.

Where needed, DoLS applications had been made to a 'Supervisory Body' for authority to provide care and treatment. DoLS decisions received were available and

Is the service effective?

remained current. The provider was complying with the conditions applied to the authorisation. Staff had a good understanding about the legal requirements of DoLS and were able to give examples of restriction and where least restrictive methods were used. For instance, rather than use bedrails to keep a person safe in bed, floor pressure mats would be considered. This would enable the person to get out of bed when they liked, but alert staff to their actions so that they could be supported if needed.

Staff understood the basis of the MCA and how to support people who did not have the capacity to make a specific decision. Staff knew capacity assessments were decision specific. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service.

Warren Lodge provides accommodation and support for older people, many of them living with dementia. The registered manager had regard to guidance in terms of best practice for a dementia care setting. For example, there were handrails in corridors to aid mobility. Bedrooms were personalised. Memory boxes outside of bedrooms contained mementos of people's lives, such as photos and trinkets. There was a memory wall on the ground floor with pictures of items used in previous times. Domestic orientation such as clocks and calendars were correct. Signage to toilets and lounge areas were easily visible and in written and pictorial forms. This helped to aid people's awareness of their surroundings.

Staff told us they felt valued, that the manager was supportive and listened to them. They received supervision at least six times a year. This included a review of their work, expectations of them, setting goals and agreeing targets and topics for review, for example, infection control and some clinical practices. Where needed, supervision processes linked to disciplinary and performance monitoring procedures. There was also a separate annual appraisal. Most staff told us it was a very supportive atmosphere. Commenting, "It's like a family" and "There was a big difference with the new manager. If you have got a problem you can go to them. You don't feel judged. They have helped out with personal issues and family commitments". Some staff felt a little unsettled because of the presence of a new registered manager and some of the changes introduced, however, they conceded many improvements were evident.

Staff described the service as clean, friendly and a homely place for people to live. They said that they would recommend the service to others, commenting, "I would not be here if I didn't like it" and "I love it here". They told us people's choices were respected, the service was not institutionalised and that if someone did not want something at one point, like personal care or food, then it was "Important to give them time and to come back; sometimes a different face worked because people responded differently to different people". They referred to and cited Bupa's philosophy of, "Person first. Dementia second". We observed a staff handover during the change of shift. This was structured and informative, giving a summary of each person in terms of their wellbeing and any as yet unmet needs.

Staff were positive about the training received and were able to tell us how they used it in their day to day role. One staff member said, "This service has high expectations of the standards of care delivery, the training I have received has helped me to deliver that". New staff members told us and records confirmed they were required to complete an induction programme and were not permitted to work alone until they had been assessed as competent in practice. Staff said they were continually supported thorough their induction period. There was a continuous programme of training for staff. Training records and certificates confirmed the training undertaken. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Staff training included other courses relevant to the needs of people supported by the service such as dementia awareness, challenging behaviour, skin integrity and skin pressure management. Staff spoke about learning how to support people before they presented behaviours that may challenge themselves or others to avoid the risk of people being hurt or upset. Comments from staff about access to training and the quality of the courses included, "The training generally is first class not

Requires improvement

Is the service effective?

just basic awareness" and "There is lots of training here". All staff were encouraged to undertake vocational training, such as Diplomas and National Vocational Qualifications in care.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. A visitor described the service as "Kind, caring and safe". They said that there was a "Caring culture" and this had been their criteria when looking for a home for their relative. They felt Warren Lodge had met this criterion when they chose the service and it continued to do so. People felt valued and recognised as individuals, telling us they were happy and content in the service. One person said, "I wouldn't want to live anywhere else". Another person told us "All of the staff are wonderful." One person commented "I was expecting Warren Lodge to be good, I'm not disappointed or wished I'd gone somewhere else. I'm very happy".

Staff were clear about how to treat people with dignity, kindness and respect. All of our observations were positive, staff used effective communication skills which demonstrated knowledge of people and showed them they were valued and thought of as individual. For example, staff spoke with people at the same level so it was easier to communicate with them or to understand what was being said. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices. Staff told people what they were doing when they supported them. They gave some people a narrative, such as your lunch has arrived, tell me what you would like to drink and would you like me to assist you. This respectfully helped people to make decisions and introduced orientation to any support they might need within the context of normal conversation. Staff were courteous and polite when speaking to people in private. They gave people time to respond and spoke in a way that was friendly and encouraged conversation.

Staff showed attention to the details of care, people's hair was brushed; they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. This level of care helped to demonstrate that staff valued and respected the people they supported. Relatives confirmed they found staff knowledgeable about the support their relative needed. They commented that whenever they visited, people seemed well cared for and happy. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the service, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us staff always contacted them if they had any concerns about their family members.

Staff knew people well and demonstrated a high regard for each person. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provide us with a good background about people's lives prior to living at the service; including what was important to people. People were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, one person became agitated. Staff spoke calmly and slowly with the person, encouraging them to speak and help them understand why they were unhappy. Staff knew how to encourage the person to remember a time when they were happier. They chatted with the person about this which helped to calm the person. Staff knew about people individually and chatted about things that were relevant to them. For example, previous jobs, where people used to live and what they did during the war.

People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had happened. Some people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care, were supported by staff and a local advocacy service.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a dignified manner. Care records were stored securely and information kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this. Care plans contained specific information about people's wishes for end of life care.

Good

Is the service responsive?

Our findings

People told us they felt staff were responsive and supportive to their needs and were offered choice in all parts of their care. They felt confident about raising any concerns with the registered manager and were involved in discussions about their care plans if they wanted to be. One person told us, "I get offered choices and decide my own daily routine." Another person commented, "I like to stay in my room and keep my own company, they know that". A relative told us they had never had to raise a complaint; they were kept informed about their relatives' care needs and were actively involved in the development of their care plan. They told us, "Any blips in care were dealt with and resolved efficiently". People said they were happy with the range of activities. Some relatives acknowledged the difficulty in trying to engage people in activities. None of the relatives raised any concerns at all about the quality of care people received from staff.

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. The assessment included consideration of the current resident group and how the potential new person would adapt to living in the service, with the people already there. Admission assessments and resulting care plans captured a holistic approach to care and included the support people required for their physical, emotional and social well-being. These included all aspects of care, and formed the basis for care planning after they moved to the service.

Care plans included people's personal hygiene care, moving and handling, nutritional needs, continence, sleeping, skin care, and pain management. A section entitled 'My day, my life, my story' contained details such as people's past life. This included their work, family, hobbies holidays as well as more personal information about if people preferred a bath or a shower; if they needed help with dressing and undressing; when they liked to get up and go to bed, and preferences about their food, their clothes, and their social activities. People's care plans were discussed with them and their family members if this was their wish. Care reviews were carried out each month and were up to date. One person told us, "My care is right". The service operated a resident of the day system, families were notified in advance and all care records to do with that person were checked, reviewed and updated. The person received one to one activities and their room was deep cleaned. This helped to ensure information remained current and care was person centred.

Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions, for example, chest and urinary infections. Care plans identified if people could communicate their needs clearly and recognised how people living with dementia could suffer from confusion. Staff realised that if people presented a behaviour that may challenge, it may be that they were trying to communicate their needs. For example, one person sometimes banged on the table when they wanted to communicate. There was information for staff on how to best communicate with the person detailing simple instructions and short sentences to maximise communication. Staff spoke about the importance of understanding body language, posture and facial expression in communicating effectively with people with dementia. Throughout the inspection our observations and daily notes showed people were cared for and supported in accordance with their individual wishes.

People told us they enjoyed the activities provided by the three employed activity coordinators, one of whom was a trained occupational therapist and another music therapist. The activity coordinators were enthusiastic and spoke positively of their role in providing for people's social needs. They were aware of people's specific interests, for example, one person's particular enjoyment of knitting and reading (Italian), both of which had been supported and encouraged. Activities and interaction logs recorded people's activities, engagement and enjoyment of activities. This enabled staff to make meaningful evaluations and suggest changes if needed. The principal activity coordinator had completed Bupa's 'Person first Dementia Second' training and was booked on an advanced course which will enable them to train other staff.

Some activities were delivered on a one to one basis where this was more suited to these people's needs. Other activities were carried out with small groups of people. There was a good recognition of people's needs and ability to benefit or otherwise from group activities. A visitor told us their relative was not an activities person and did not like to join in with group activity sessions. They explained the person had been a company director and this was very

Good

Is the service responsive?

much the world they still lived in. They told us the person was invited to sit in on staff meetings, which had really helped them retain their sense of self. The relative commented, "It had taken a few months for my relative settle here. The staff have worked really hard to do this and have joined him in his world". Other people told us the location worked well and they enjoyed looking out of the window at the people, lorries and traffic passing by. Activities were innovative and wide ranging and included music, religious ceremonies, dance and PAT dogs as well as a visit from a lama and a pony. There was an emphasis on olfactory sensory activities for evoking memories from smells such as a sensory garden of herbs and spices, cooking and baking groups. Physical activities included floor snakes and ladders, balloon volley ball, quoits, newspaper reviews, and time with families. In addition the service utilised volunteers as well as work placement students, all of whom enriched the environment.

Staff told us about map therapy, using maps of people's past home towns and other familiar places as an object of reference. This prompted reminiscence, invoked memories and led to feelings and emotions being expressed. This helped staff learn more about people's personality and character, which in turn was shared with care staff to aid and enhance the day to day communication with people and the quality of care provided.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts, but also encouraged people to raise any concerns or complaints with staff or the registered manager. The registered manager had an 'open door' policy and made herself available to people and their relatives, this was evident during our inspection. There was a system for people to write down any concerns and staff told us how they would support people doing this. Documentation showed that all concerns and complaints were taken seriously, investigated, and responded to in a timely way. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in post. People and visitors were complementary about the registered manager and staff, commenting positively about how approachable they were. People told us they felt staff made time for them. We saw and comments confirmed that the registered manager had made a positive difference to the running of the service. People and their relatives felt she was thorough when dealing with an issue and would ensure it was addressed quickly.

The registered manager and key staff undertook regular checks of the service to make sure it was safe and met people's needs. These included areas such as infection control, medicine management, pressure ulcer and wound care, nutrition, mobility and care plan quality. In addition a programme of monthly audits completed by the Area and Quality Managers helped to support governance processes and reviewed the quality of life for people, the environment they lived in, care, leadership, operational processes and systems. Where checks identified concerns, action plans, timescales and accountable staff ensured they were addressed. However, the concerns identified during this inspection illustrated that the quality assurance measures in place were not fully effective. This was because they had not recognised or put measures in place to resolve areas where regulations were breached. These include the unsafe storage of medicines, incomplete recruitment risk assessment processes and a lack of fire drills. Therefore, systems had not ensured continuous oversight of all aspects of the service. This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a service receives a decision from local authorities in response to an application made under Deprivation of Liberty Safeguards. This is where restrictions are needed to help keep people safe in the service. Statutory notifications informing us about six decisions had not been made to The Commission.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 18 4(A)(B) of the Care Quality Commission (Registration) Regulations 2009.

Established systems sought the views of people, relatives, staff and health and social care professionals. Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. Where people had made suggestions, these were well received and acted upon. For example, the provision of a wheelchair ramp and more pictorial reference material to help people choose meals. A system called 'You said, we did' ensured people were aware of all suggestions made and what had happened.

Staff meetings occurred monthly, were held in the afternoon and evenings to include daytime and night shift staff across all of the units in the service. Staff said it was not always possible to attend these meetings and that they were not always relevant to their work. However, they told us that more focussed meetings did take place on a day to day basis on their own units and that they found these more helpful and informative in relation to teamwork and supporting people. Any actions resulting from meetings were assigned to a member of staff to follow up and feedback.

There was a positive and open culture within the service. Staff told us they found the management at the service supportive and felt the staff team worked closely. A member of staff commented, "There is a genuine open door policy. The manager and visiting operational managers are easy to talk to. You can discuss any ideas or concerns and they encourage suggestions". Other staff told us, "We have a good staff team at here, we all work well together, it's positive for us and for the people we support".

The Registered Nurses spoken with felt wholly supported by the management team, including the re validation requirements made by The Nursing and Midwifery Council (NMC) for Registered Nurses, commencing in 2016, to continue practicing as a registered nurse. They felt there was an inclusive culture where they could raise concern, make suggestions on improvements and they would be

Requires improvement

Is the service well-led?

listened to. For example, leadership development training was identified as useful and now in place. The post of Clinical Manager was seen as a great asset; completing audits care files, monitoring accident and incidents, wound care and ensuring that all the clinical care needs were addressed.

The service had a clear principle about their commitment to the people they supported. Their approach to care focused on respect and dignity and taking the time to get to know each individual person – not just their condition. This ethos was embodied in the service's commitment to their approach of 'Person first, Dementia second'. This included being respectful, inclusive, reliable, open and honest. The registered manager told us that the values and ideology of the service were embedded in the behaviours staff were expected to exhibit. Staff confirmed the values of the service and expected behaviours were discussed at supervisions and in team meetings. We saw examples of staff displaying these values during our inspection, particularly in their commitment to care and support and the respectful ways in which it was delivered. Staff, people and visitors were able to nominate staff as 'everyday heroes' in recognition of good work and going the extra mile.

The service looked at the support of people holistically, including offering support to family members. The service used Admiral Nurses who are specialist dementia nurses to give expert practical, clinical and emotional support to families living with dementia to help them cope. They are registered nurses, and have significant experience of working with people with dementia before becoming an Admiral Nurse. Events attended or hosted by the service helped to raise awareness around the local community of caring for the elderly and people living with dementia. Membership of trade associations and access to leading dementia specialists within the organisation helped to inform best working practices and methods of support, care and treatment.

During the inspection anything identified by the inspection team was immediately rectified or investigated. This demonstrated a receptive, responsive staff and management team, who were open to the suggestions and observations made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including doing all that is reasonably practicable to mitigate any such risks in the event of an emergency and ensuring the proper and safe storage of medicines and following planned care and treatment pathways.** Regulation 12 (1)(2)(b)(d)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures were not operated effectively to ensure people were protected as far as practicably possible by a safe recruitment system.** Regulation 19 (1)(a)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to assess and improve the quality and safety of the services provided and mitigate risks.** Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not notified the Commission the outcome of requests to a supervisory body for standard authorisations under the Mental Capacity Act 2005. Regulation 18 4 (A)(B)CQC (Registration) Regulations 2009.