Caring Homes Healthcare Group Limited

Ferfoot Care Home

Inspection report

Old and New House,The Folly
Old Hardenhuish Lane
Chippenham
Wiltshire
SN14 6HH

Tel: 01249658677
Website: www.caringhomes.org

Date of inspection visit:
23 August 2018
24 August 2018

Date of publication:
10 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 August 2018. The first day of the inspection was unannounced.

Ferfoot Care Home, is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ferfoot Care Home accommodates 52 people in one building. On the first day of the inspection, there were 39 people living at the home. The home was registered to support people living with dementia and their nursing needs, over the age of 65 years.

The building was divided into two adjoining units. Each unit contained people's bedrooms, a lounge and quiet lounge, a dining room and communal bathrooms and toilets. There was a central kitchen and laundry room.

At the inspection in September 2016, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result, we placed a condition on the provider's registration. This required the provider to notify the Care Quality Commission, on a monthly basis, of the action being taken to address the shortfalls identified. The provider has adhered to the condition. At the following inspection in May 2017, improvements had been made and the home's rating was changed from inadequate to requires improvement. At this inspection, further improvements had been made.

The registered manager left employment at the home in May 2018. A manager from within the organisation was covering the role. They said they were in the process of registering with the Care Quality Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was positive feedback about the new manager and the improvements that were being made. There was an on-going improvement plan and the manager had "put a hold" on new admissions until changes had been embedded. The admission criterion had been reviewed to ensure the home stabilised and there were clear assurances people's needs could be met.

The cleanliness of the environment had improved and there was less odour. Carpets had been replaced with flooring that could more easily be cleaned. There were however, some areas such as communal toilets that required additional focus.

Some risks to people's safety had not been identified. This included an urn in the dining room and a propped open fire door, which led to steps to a lower level. Action was taken to address the risks once

brought to staff's attention.

New staff were being recruited using safe recruitment practice and focus had been given to staff training. The training, particularly that of dementia care had improved interactions and an understanding of the person's condition. However, some practices such as a music entertainment activity and the lunch time meal experience, were not conducive to some people's needs.

People could personalise their bedrooms yet other areas such as the corridors were bland. There were limited pictures, signage and textures which did not enable people to find their way around easily. A senior manager told us consideration was being given to brightening the environment. This included painting people's bedroom doors white.

Incidents, which involved falls and behaviours that challenged had been analysed. This had identified the majority of incidents had occurred during the late afternoon and evening. To minimise further occurrences, the numbers of staff were increased to ten. This had worked well and a decrease in incidents had been seen.

Improvements had been made to the planning of people's care. Care plans were much more detailed and person centred although some information, particularly around people's health care needs was more limited. Risks such as falling, choking, malnutrition and the development of pressure ulceration had been assessed and were being appropriately addressed.

People had enough to eat and drink. This included a choice of each meal and regular sweet and savoury snacks throughout the day. Any weight loss was monitored with additional and fortified foods given as required.

People were encouraged to make decisions and staff asked for consent before undertaking any care intervention. Staff promoted people's dignity although some people had debris under their fingers nails. Staff explained the reason for this but such detail was not documented in the person's care plan.

Improvements had been made to the safe management of medicines. Staff followed procedure and took their time when administering people's medicines. Information was available for staff regarding "as required" medicines although not all was personalised to show the person's needs or preferences.

People were encouraged to remain healthy and had good access to health care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risks to people's safety had not been identified.

Improvements had been made to the cleanliness of the home and infection control.

Medicines were safely managed.

There were enough staff to support people safely.

Staff recruitment was being followed.

Is the service effective?

Good

The service was effective.

The environment did not enable people to find their way around easily.

Decision making was undertaken in line with the Mental Capacity Act 2005.

People had enough to eat and drink.

People were supported by a range of health and social care professionals.

Is the service caring?

Good

The service was caring.

People's dignity was promoted although some people's finger nails were not clean.

There were positive interactions and staff spoke about people with fondness.

People and their relatives were complimentary about the staff team.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some practices such as a music entertainment activity, increased some people's anxiety.

Improvements had been made to people's care plans to make them more detailed and person centred.

People were able to join in with a range of social activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager was in the process of becoming the registered manager.

Improvements were being made to the service and time was being given for them to embed.

An improvement plan and audits were in place although some risks had not been identified.

Ferfoot Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 23 and 24 August 2018. The first day of the inspection was unannounced. There were three inspectors and an expert by experience on both days of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection visit we reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

To gain feedback about the service, we spoke to six people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six relatives, 12 members of staff and one health care professional.

Requires Improvement

Is the service safe?

Our findings

At the inspection in September 2016, we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there had been continued shortfalls, in the management of people's medicines and the cleanliness of the environment. At the inspection in May 2017, improvements had been made in these areas. However, there was further work to do and time was needed to embed all changes.

At this inspection, further improvements had been made to cleanliness and there was less odour. Many of the carpets, including those in the corridors and some people's bedrooms, had been replaced with laminate flooring. One member of staff told us this had made a difference. They said, "It's much easier to keep it clean here now." However, the carpet in one of the lounges was stained. There were two raised toilet seats in the downstairs communal toilets, which were also stained and urine on floor in one. This was brought to the attention of staff and addressed. Within a person's bedroom, the toilet had not been flushed and there were brown smears, around the toilet pan and on the soap dispenser.

People and their relatives were generally happy with the cleanliness of the environment. One person told us, "My room is kept very clean". A relative said, "The room is always spotless and the bedding is kept clean". However, one relative told us cleaning could be better. They said, "It's not bad, but sometimes it's the attention to detail that's not there. The underside of things isn't always cleaned, and some of the chairs in the rooms are quite shabby and not washable. They could do with being replaced." A person told us, "My room is cleaned, but I'm not happy that my bed doesn't get changed every week. If [name of staff member] is here it's done but otherwise it doesn't happen, and I think it should".

Systems were in place to minimise the risk of infection. For example, a coded laundry bag system ensured soiled items were kept and washed separately from other garments. Disposable protective clothing, such as gloves and aprons were available to staff as required. Staff used tongs when servings snacks to people, so they did touch the food.

People's medicines were safely managed. A member of staff took their time and followed procedure when giving people their medicines. Staff had appropriately signed the medicine administration record to show they had administered the medicines. A process to check this had been introduced. There was clear documentation to inform staff of the application of people's topical creams. However, within one person's room, there was a topical cream which had been prescribed for another person. This was brought to the attention of staff and the cream was removed.

On three occasions in August, the thermometer to show the temperature of the medicines fridge had not been working. This meant no temperature had been taken, which did not ensure the medicines were safely stored. On the second day of the inspection, staff told us a new thermometer had been ordered. The provider's medicine management policy stated, in line with current guidance, that the recommended maximum temperature for the storage of medicines was 25 degrees. Staff had identified the clinical room had on occasions been higher than this. They had opened the window in response but not documented that

they had re-checked to ensure the temperature had reduced. On the second day of the inspection, staff had implemented a new form to prompt staff to do this.

Some people were prescribed medicines to be taken "as required". There was information to guide staff about the administration of these medicines although not all was personalised. For example, one record did not show signs of a person's anxiety and what interventions staff should try, before administering their medicine. The reasons for administering "as required" medicines were not always stated. This included documenting why one person had been given pain relief, four times a day for a month. This did not enable trends to be identified, which might require a GP review.

Staff had received training and regular audits of the medicine systems were carried out. Records showed any shortfalls identified were addressed. All recommendations identified during a pharmacist's visit, had also been implemented. This had included writing expiry dates on bottles, when they had been opened.

People and their relatives had no concerns about the management of medicines. One relative told us, "The doctor has taken [family member] off most of their medication and that's been a good thing, I'm very happy with how they look after their medicines." Another relative told us, "They seem to give it all on time, when I'm here visiting." One relative said staff managed their family member's pain well.

Some risks to people's safety had not been appropriately identified or addressed. For example, there was an urn in the dining room, which staff used to make hot drinks. This was easily accessible to people and if used inappropriately, could sustain significant burns. Once brought to the attention of management, a risk assessment was undertaken. A senior manager told us the urn would be removed. Other risks to the environment, were actioned when raised with the staff team.

Other risks to people's safety, in areas such as falling, choking and malnutrition, had been identified. Measures to minimise such risks were in place. For example, staff had identified one person was at risk of falling from their chair. They had contacted an occupational therapist and as a result, a specialist chair had been purchased. Equipment people used to help with them move safely was documented within their care plan. This included the type of sling and hoist the person used. Assessments showed the use of bed rails. One person had used a less restrictive option and had their bed lowered with a 'crash' mat next to it. After three consecutive nights of falling from their bed onto the mat, the bedrails were introduced to ensure safety.

One person had a choking incident whilst eating, which required staff to clear their airway. Following the incident, a care plan had been developed, which stated the person should have a member of staff with them at meal times. This was followed and the person had also been referred for a swallowing assessment.

Nationally recognised assessment tools were used to assess people's risk of malnutrition and developing pressure ulceration. Care plans had been devised in relation to the outcome of the assessment and equipment was in place, to minimise identified risk. This included pressure relieving mattresses and cushions. The mattresses were set on the correct setting although one care plan stated the person had an airflow mattress. This was incorrect as it was a Propad mattress which offered less protection. Records showed those people at risk of pressure ulceration had their position changed as required although on the first day of the inspection at 9:38am, the record had already been completed for 10:00am.

Accidents and incidents were reported although records did not always show appropriate action had been taken following an event. For example, one person had fallen and sustained injuries to their face. The person was reviewed at hospital, with the advice on discharge, "I have reminded the staff at the nursing home that

patients on anti-coagulation therapy with a head injury should be referred to the emergency department urgently, on the same day." Shortly afterwards, another person on anti-coagulation therapy fell and sustained a bruise under their eye and on their chin. Two staff told us the person had not received emergency support or been reviewed by the GP. This meant the person's safety was compromised, as the hospital's advice, had not been followed. Care plans were in place for those people on anti-coagulation therapy. However, these were not completed with immediate effect following the advice from the hospital.

Two relatives told us safety had improved. One relative said, "Before the new manager came, I felt I couldn't rely on anyone and [family member] was often left in their room without anyone checking. I felt some of the staff didn't care but a lot of the carers have left, and the new staff are lovely. I'm much happier. I used to feel I had to come in every day and phone up, as I couldn't trust them." Another relative said, "I feel [family member] is safe. I've got less on my shoulders, I've got my life back."

Whilst there was positive feedback about safety, there was some concern about people going into bedrooms which were not theirs. One relative said people had tried to get into their family member's bed or sit in their chair. They said this was a risk, as people were often agitated and could cause harm. The relative told us, "It does worry me." One person told us, "People do wander in sometimes but I just shout at them to go away and they do." Other people told us they had a key to their room to minimise people walking in uninvited. The manager told us they would consider this.

Staff were aware of their responsibilities to identify and report a suspicion or allegation of abuse. They had received safeguarding training and a copy of the safeguarding procedure was displayed in the care office. Records showed physical altercations between people, had been reported to the local safeguarding team. A senior manager told us a new telephone line had been implemented, for relatives and staff to report any suspicions or allegations of abuse.

There were enough staff to support people. Call bells were answered in a timely manner and there was a staff presence, although a peripatetic manager identified staff were not in a communal lounge, as they walked through. They addressed this with staff and there were no further occasions of this. The manager told us they had undertaken a falls analysis, which found most accidents and incidents occurred later in the day. As a result of this, the number of staff on duty during the afternoon and evening, had been increased to ten.

Staff confirmed staffing levels had improved, which had seen a positive impact on people. One member of staff said, "Higher staff numbers means more time to spend with people. It used to be rushed, now we have more time to sit and talk to people. We're not time oriented anymore." Another staff member said, "It's a lot better now we have more staff. Falls have reduced." Staff told us in addition to the extra staff, they could call upon agency staff to help where needed.

People and their relatives told us there were enough staff. One person told us, "I don't often ring, as I can do most things for myself, but recently I had to and two staff came pretty much immediately." A relative told us, "They [staff] are always around keeping an eye." Other comments were, "I've always been able to find someone if I've needed them" and, "I have never seen a delay in [family member] getting the necessary care." A health and social care professional told us staffing had improved and there was now a staff presence in all areas of the home. They said they could find a staff member to assist them, which did not previously happen.

Safe recruitment practice was being followed. Records showed various checks were undertaken such as the prospective staff member's past work performance, fitness and character. There were also checks of the

prospective staff member's identity and a Disclosure and Barring Service (DBS) disclosure was completed. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Good

Is the service effective?

Our findings

The home was made up of the 'old' and 'new' wing. Each wing had its own lounge, dining room, bathroom and toilets with a central kitchen and laundry room. However, the environment did not enable people to find their way around easily. For example, there was limited signage to direct people where they wanted to go and some areas lacked colour and stimulation. There were limited pictures in the corridors and walls were painted a similar colour. A senior manager told us there were plans to paint bedroom doors white to make the corridors lighter. Some people did not have their name or a distinguishing feature on their bedroom door. The manager and senior manager told us they were aware of this. They said laminated pictures had been placed on the doors but people had taken them off, as they walked around.

People could make their room homely by bringing personal possessions with them on admission. They said they were happy with their room. One person told us, "I like my room, I've been able to bring my own things and I've got an en-suite which I really like. In fact, that's one of the reasons why I chose to stay, I wouldn't want to give my room up". Relatives also commented positively about their family member's room. One relative told us, "You can do whatever you want with the room. We're going to bring a chair from home and have brought in photographs which are all named so that staff can help [family member] to recall who's in them."

People were assessed before moving to the service. One person told us this had been a gradual process, which had worked well. A relative was equally positive and said they had been fully involved in the assessment of their family member. Another relative said, "I discussed [family member's] care and needs at the beginning, and that's been ongoing". However, information about one person's assessed needs had not been transferred to their care plan. This increased the risk of them not receiving the support they needed.

People had enough to eat and drink. There was a choice of meal and drinks, as well as sweet and savoury snacks throughout the day. Alternatives were offered for those people who did not like what was on the menu. A staff member confirmed this by saying, "We don't offer set alternatives. If we have it, people can have what they fancy." Records showed within one unit, 18 out of 20 people had maintained or put on weight. The two people who had lost weight, had been offered regular snacks between meals and had been seen by the GP. Relatives were aware of any concerns about their family member's weight. They said their family member was given fortified foods, if required.

The mealtime experience was varied. One member of staff assisted a person with their lunch in a friendly and attentive manner. They approached the person and said, "Hello [person's name], I've got your lunch. Shall I put this [clothes protector] over you?" The staff member spoke to the person throughout the meal and offered small spoonful's. They checked the person had swallowed each spoonful before offering any more. However, on the second day of the inspection, another member of staff assisted the same person. They did not engage in any conversation, apart from saying, "Open your mouth please." They used a spoon to place food in the person's mouth and intermittently used the same spoon to give them thickened fluids. They did not ask or check the person had swallowed their food before offering more. Additionally, the member of staff did not give the person their full attention, as they were looking at the television.

People and their relatives were complimentary about the food. One person told us, "The food is very good, there's enough choice and you can ask for alternatives. The cook does me a salad, which I prefer to veg. There are snacks around, and I do take fruit and crisps when I'm hungry. It's lovely to have them there and I can get a drink if I want one." A relative told us, "I'm impressed with the food and [family member] is eating very well indeed and has gained weight."

People were supported to remain healthy. They had access to a range of health and social care professionals. This included the GP, district nurse, mental health team and occupational therapist. Some people received specific support and advice regarding their health care condition such as the Parkinson's nurse. One person told us, "I go to appointments outside for podiatry, the diabetes clinic". Records showed staff were prompt in referring people for assessment. For example, one person displayed behaviours that challenged so a review by a consultant psychiatrist was arranged. They prescribed alternative medication, which was working well. A relative told us, "The doctor comes in every week and my [family member] always sees the doctor if necessary. The staff will call them in if it's urgent". Hospital transfer booklets were in people's care files. The booklets contained short descriptions of the person's needs should they need to go to hospital.

Relatives told us staff were good at identifying any changes in their family member's health. Specific comments were, "Usually when I speak to the staff about something I've noticed, they're already aware of it and that reassures me. They do notice" and "I feel confident that they'll get the doctor if [family member] is unwell, and they'll let me know". One relative told us, "They've dealt with my [family member's] infection well. They've managed the pain, and kept the area covered over to prevent it rubbing and being sore." A healthcare professional told us staff were now more aware of any concerns with people's health. They said more staff and greater supervision, had lessened the number of falls and altercations. This had meant less abrasions and skin tears.

Staff had received a range of training to help them do their job effectively. This included training deemed mandatory by the provider and other topics related to people's needs. One member of staff said, "The Living in my world dementia training is very good. I learnt to consider what is going through people's minds. It was really useful." Another member of staff said, "I've just done a falls prevention course. It made me much more aware of potential causes." One member of staff told us whilst they had undertaken all their mandatory training, they felt more face to face training in different topics would be of benefit. A senior manager told us this had been identified and was being addressed.

Records showed new staff completed the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. However, new ancillary staff told us they had not undertaken training in keeping themselves or others safe, in the event of an altercation.

Relatives told us staff had the skills to support their family member. One relative told us, "I think the staff manage [family member], who can be difficult, very well. The way they handle those situations is really good." Another relative said, "The staff are skilled, some more than others but they are especially good with [family member] and getting them to do things in a kind way." A health and social care professional told us staff's knowledge about people had improved. They said, "We used to ask staff about people and the answer would be, "I don't know" or "I wasn't here" but now, we ask and they can tell us exactly. They're knowledgeable about people and want to learn."

Staff told us they felt supported and listened to. They said they gained support on a day to day basis and more formally, when meeting their supervisor. The one to one meetings enabled topics such as work

performance, training needs and any concerns, to be discussed with actions agreed if required. Staff told us the additional support they received from the new manager and the developments within the home had improved morale and team work. This was shown during the inspection, as staff moved across both units, to assist each other. One member of staff told us they only supported those people they felt confident with. They said they were observing or working with other staff to develop their skills in managing more complex needs.

The Mental Capacity Act 2005 (MCA) was followed appropriately. The manager told us a lot of work had been done to ensure this. The 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's capacity to consent to aspects of their care had been assessed. Relatives had been involved, when their family member had been assessed as not having capacity to make certain decisions. One relative told us, "I'm involved in important decisions on my [family member's] behalf. The everyday things [family member] is able to make choices on their own." Another relative told us, "I've got LPA and I'm involved in making decisions about care and treatment. The staff always make sure I'm involved". One relative told us they had been involved in a best interest decision for their family member, regarding them going out of the home. Records showed best interest decisions had been made in areas such as living at the service and the use of bed rails, sensor mats and reclining chairs. However, staff held one person's cigarettes and gave them one every hour. Staff told us this had been agreed with the GP but up to date documentation to evidence this was not available. A member of staff told us this would be addressed.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed DoLS applications and urgent authorisations, had been made as required. The majority had been made since June 2018.

People told us staff asked for consent before assisting them with their care. One person told us, "They wouldn't do anything without asking you first, and it wouldn't be a problem if you said no, as they do give you your choice". Another person said, "It's always your choice what you do, for example, I'm offered a bath but I usually prefer to have a wash. You can come down and take part in entertainment on offer, but it's always up to you. The staff never pressurise anybody."

People were encouraged to make choices although one person told us this depended on the staff on duty. Other comments included, "If I don't come down for breakfast, the staff come to see if I'm ok and ask me if I want breakfast in my room. I can have my choice. They don't tell me to get up" and, "The staff never make you do anything you don't want to. You get a choice and they respect that."

Good

Is the service caring?

Our findings

People's dignity was promoted although some people had dirty finger nails. Staff explained on occasions, one person used their fingers to pick up their food. This meant the person's finger nails collected food debris but they did not like them cleaned. There was no guidance within the person's care plan to guide staff on how to manage this. The information did not show any techniques, which could be used, to support the person with their nail care. Other people looked well supported in terms of their personal care. Some of the ladies were wearing jewellery and had their handbags with them. Records showed one person had a bath nearly every other day, as they had requested this. The manager told us focus had been given to dignity and dignity champions were being developed.

The manager told us they spent time "on the floor", talking to people and their relatives and working with staff. They said they observed staff interactions with people, to ensure the standard of kindness, respect and compassion they expected, was upheld at all times. The manager told us they liked to "get out there" with people and staff, rather than spending large amounts of time in the office. They said this included regular "walk arounds" and sitting with people, to enhance relationships. The manager told us "getting the right staff" went a long way to ensuring kindness and compassion. They said they had been selective on who they had recruited, to ensure this.

Staff told us the development of a new staff team and their dementia care training had helped interactions with people. One member of staff told us, "We see past the dementia. We have some incredible, intelligent people here. We have headmistresses, mechanics, people from the forces, all very intelligent people. We need to hold on to that when we're supporting people." The member of staff continued to say, "I asked the person the other day, how to fly a helicopter. It was amazing." Another member of staff told us, "Putting ourselves in their shoes is humbling. We can't understand what it must be like to live with dementia but it gives us a sense."

Staff were confident when talking about how they promoted people's privacy and dignity. One member of staff said, "When we provide personal care, we always make sure the door is closed and the curtains drawn. If the district nurse comes and the resident was happy to be seen in the lounge for example, then we'll put a screen up."

People told us staff respected their privacy and dignity. One person told us, "I do feel that my room is private. Staff always knock and wait to be invited in first." Another person said, "They usually knock on the door and call out before they come in." One person told us, "There are a lot of new male carers and they're all very nice but I wouldn't want them to bath me. No-one has asked me if I mind, but I would just say so. It would be alright, as they never expect you to do something you don't want to do."

Staff spoke about people with fondness and showed a supportive and compassionate manner within interactions. One person was upset and a member of staff gave comfort through a hug. The person responded with a smile and laughed. Another member of staff supported a person to go to the bathroom. They spoke softly and discreetly and said, "Come with me. I know where you want to go, and I'm going to

take you there." One person had dropped some food on their clothing. Staff made them aware of this and offered to help them change. Another member of staff asked a person if they wanted to go to the dining room for lunch. The person looked unsure and asked, "Who are you?" The member of staff told the person their name but they could not grasp this. They then knelt with the person and showed them their name badge. The person looked closely and then smiled, whilst repeating the name. Both walked to the dining room, arm in arm and chatted as they did so.

People were complimentary about the staff. One person told us, "The staff are really kind. When I first came here, they came in to my room and made sure I was alright. They were understanding and listened to me. They're all lovely, and respectful." Another person said, "The staff are really kind here. They take time to listen and they know I'm not stupid, it makes all the difference." Other comments were, "The staff are all very kind and nice. They're always there if you have a problem", "You feel listened to, the staff do listen to you. That's important" and, "They are caring and if you're not well, and have to stay in your room, they look after you very well".

Relatives also gave positive feedback about the staff. One relative told us, "The staff are caring. They also speak to my [family member] respectfully and appropriately." Another relative said, "It took [family member] a long time to settle here. Staff have developed a rapport with [family member] and gradually involved them more in activities. There's banter." Other comments were, "The staff are caring and accommodating" and, "The staff always speak to [family member] respectfully and offer choices. For example, about food and drink or where to sit."

Staff encouraged decision making. This included offering choices about food, drink and activities. One member of staff asked a person, who had just sat down in the lounge, "Would you like me to get you a cup of tea or coffee? How do you take it?" Another member of staff asked a person, "We've got the church service today. Would you like to come through?" The person declined and the member of staff said, "That's ok, if you change your mind, let me know." Another person was trying to open the door to the garden. A member of staff identified this and said, "Would you like to go outside? Shall I come for a walk with you?"

Records showed people and their relatives were encouraged to be involved in the care planning process. This included taking part in care reviews. One relative told us, "Every now and again we sit down together and they let me know how [family member] is doing. We talk about what's changed, and decide how the care will adjust." Another relative said, "I've gone through the care plan and I'm happy with it. I've signed it off."

Requires Improvement

Is the service responsive?

Our findings

Staff generally showed an understanding of people's needs. However, on the first day of the inspection, the radio was on in the dining room and there was musical entertainment in the adjoining lounge. This, and staff encouraging people to join in, was very loud. As time went on, those people with greater cognitive impairment, became agitated. A peripatetic manager identified this and asked staff to reduce the noise. On the second day of the inspection, musical entertainment took place in another lounge. This meant the sound was more contained, which worked well.

At lunch time, people were offered a visual choice of the meal on offer. This was an improvement on practice for some people. However, showing a visual choice of food was not conducive to each person's needs. For example, some people did not understand and tried to take the food from the plate. Some people needed to wait up to 20 minutes, from when they had chosen, to when their meal was served. Two people fell asleep before their food arrived and there was a risk that people had forgotten what they had ordered. There was an additional delay before desserts were served. This meant some people became unsettled and left the table, needing staff to encourage them to return.

One person was in bed but their sensor mat, which informed staff if they got up, was under their bed and not being used. This was brought to the attention of staff, who immediately put the mat in place. An assessment showed the person needed to be checked every hour whilst in bed. Records did not show these checks had been undertaken.

Improvements had been made to people's care plans. For example, information in relation to people's dementia care needs was personalised. One plan explained why a person might say certain things and how it was related to the job they used to have. Staff had documented another person could become frustrated and argue with other people. There was clear guidance for staff on how to de-escalate the situation if it arose. Another plan described how a person expressed they were in pain. This was by becoming agitated and muddling their words. One plan showed what could trigger a person's behaviour, which could be challenging.

Other plans contained further person-centred information. This included, people's preferences for a male or female member of staff to support them. In one plan staff had written, "Likes to look well dressed, costume jewellery, weekly hairdresser." Another plan stated, "Likes a wet shave every day. Likes to look smart and most days will wear a tie." There were one-page profiles, which contained details such as 'my background and things important to me', 'how you can support me' and 'my essential care needs'.

Some information however, was less detailed. One plan for example, stated the person had "specific routines" but these were not expanded upon. Two people had diabetes and whilst complications such as hypo or hyperglycaemia, were detailed in the policy manual and addressed within first aid training, information was not identified in either person's care plan. This did not ensure staff had the required information to support the person if they experienced these conditions. One plan stated the person did not always follow a diabetic diet, whilst another plan said the person enjoyed "sweet foods". The information

did not detail how these choices impacted on the person's diabetes and how they were managed.

Information within people's daily records was not always sufficiently detailed. For example, within one record staff had recorded the person had fallen but a clear time line of what had happened or what action staff had taken, was not stated. Other records contained terminology such as "personal care given". The information was not specific and did not for show for example, if the person had been offered a bath or shower. The information of having a bath was identified within bathrooms, on a record which was used to check hot water temperatures rather than people's care records. A member of staff told us another person had a bed bath twice a week. There were no written entries for the ten-day period before the inspection, to show this.

People and their relatives were complimentary about the quality of care provided. One person told us, "I'm settled here. I love it and love the people, the entertainment and the atmosphere, I'm happy and I don't want to leave." Another person said, "It's very good here. I've got nothing to complain about and I'm well looked after and able to do what I can for myself. You can always do what you want to do here." A relative told us, "My [family member] can be very challenging and the staff do a very good job. They look after all their needs and mine too." Another relative told us, "Care is sensitive and responsive to my [family member's] wishes and preferences". One relative however told us, "There are sometimes problems with consistency in staff. Sometimes everyday communication falls down, like not being told that [family member] has gone out on the minibus and getting here to find that out. Things like glasses not being on or hair not being brushed at the back but overall, the care here suits my [family member's] needs and I'm impressed."

There were advanced care plans, which enabled people to express their wishes about their end of life care. The format of the plans was comprehensive and covered areas such as pain management, comfort and spiritual needs. There was also information about hospitalisation, resuscitation and funeral arrangements. Whilst the format was detailed, not all the plans were fully completed. A senior manager told us they were aware of this and were piloting new documentation within the organisation. If successful, this would be implemented within the home. A peripatetic manager told us they were hoping to support the home with implementing the Gold Standards Framework. This is a nationally recognised initiative to ensure each person has a "good death".

One relative told us they had been involved in discussions about their family member's "end of life" care. They told us, "They [staff] have talked to me about end of life, how things might go and what [family member's] care needs might be and how they'll look after them. I've been involved in deciding what will happen when there's a deterioration and I'm reassured [family member] will stay here and that they can manage everything."

People could join in with a range of organised social activities. During the inspection, there was a religious service, bingo, a music quiz and musical entertainment. Staff encouraged people to join in by asking them to dance or sing with them. One person was given a book, which related to their interests. Another person was asked if they wanted to do some colouring. However, neither person engaged with these activities and staff did not stimulate their interest. Other people were sitting at a table with a jigsaw. A member of staff, sat down and a person said, "ah, we were waiting for you to come". The staff member prompted and guided individual participation, and each person remained engaged for the time the staff member was present. This did not continue, when the staff member left. In one unit, books, games and tactile objects were placed on tables. Staff encouraged and then supported people to use these. Activities and people's participation were documented within specific engagement documents. The information showed regular group and one to one activities took place. One member of staff told us the home had its own transport, which they shared

with another service within the organisation. They said they were looking to further improve external activities for people.

People and their relatives told us they would speak to staff or the manager if they had a concern. Specific comments were, "I suppose I'd talk to the manager if I needed to, but I haven't needed to" and "I've never needed to complain about anything, but I'd talk to a 'senior'." One person told us "The staff are lovely. I've never had any problems with any of them. If I did I suppose I'd talk to the manager."

People and their relatives told us whilst they had not needed to make a formal complaint, they had raised some minor concerns. They said these were dealt with effectively and they were satisfied with the outcomes. For example, one relative told us, "Small things that have happened, I've dealt with them at the time with the person concerned and I've been happy with the outcome." Another relative said, "Any little concerns I've had to raise have always been dealt with."

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager. A manager had been employed and was in the process of applying to the Care Quality Commission to become the registered manager. The manager said they had initially spent time with people, their relatives and staff to get to know them and to learn about how the service was performing. Whilst doing this, they worked with staff to ensure safety and started to implement change. They reviewed the admission criteria and identified some people's needs would be better met elsewhere. This altered the atmosphere of the home, enabling a more relaxed and quieter environment. The manager told us they had also restricted admissions, to stabilise the home. The number of staff on duty had been reviewed and areas of need were responded to. Agency staff were used to cover any shortfalls, with recruitment of new staff given additional focus.

There was a lot of positive feedback about the improvements that had been made within the home. A relative told us, "It was terrible, going downhill, and the staff weren't caring. For example, after I'd spent all day with my [family member] in hospital. We got back and no-one came to support [family member] or me, or to ask if we needed anything but it's a different place now." Another relative said that in the past they had been concerned, as they felt their family member had not been given enough assistance with food and fluids. They told us, "I felt I didn't have any guarantee that food or drinks had been given. The staff do regular rounds now and will go in and give [family member] a drink. Before there were things on the table or spilled on the floor, and nobody had been in to help, or to see that it hadn't been taken." However, one observation of people being up in the lounge early but sleeping was raised. The concern was that people were being assisted to get washed and dressed too early, as a matter of routine. The manager said they were not aware of this but would investigate the concern.

Staff were equally positive about the changes that had been made. One member of staff told us, "It's like a different place. It feels different. There's no stress. We have enough staff and are not expected to be short staffed. People are happier. It's more relaxed. It's a real pleasure to come to work." Another member of staff told us, "What a difference. We needed to change. It wasn't good but now we have a good staff team and a good manager. It is so much better you wouldn't believe."

The manager told us the staff team were developing well and taking on board any changes. They said staff wanted the home to succeed and were working in line with its vision of providing people with good quality care. One member of staff confirmed this. They told us, "It's not been easy but we needed to be humble and look at what was going wrong. I think we've done that, now we need to embed the changes and look at further developing." Another member of staff said, "It's so much better. We can provide good quality care now, as we have the resources to do it." They continued to say, "I'm really proud of what we've achieved since the last manager left. The home is alive and people have meaningful things to do."

There was positive feedback about the manager. One relative told us, "I'm happy now. I can talk to the new manager and she listens. In the past that hasn't always been the case. Now staff listen and act on what you ask and they treat you well." Another relative told us they had experienced some problems with staff attitudes in the past, although they were now much happier. They told us, "The current manager and new

staff are more caring. The manager is very good, and I'm happy, really happy." However, there was some concern the manager would not remain in post and the home would return to how it was. The manager told us they were looking to embed the positive changes fully so it was recognised practice.

Audits were being undertaken and an ongoing action plan was in place. A peripatetic manager had been deployed to the home to assist with improvements, particularly in relation to people's dementia care needs. They said they had worked with staff to develop interactions, care planning and the techniques to use, when managing behaviour that challenged. The peripatetic manager told us any incidents, which involved behaviours that challenged had been analysed. This included looking at incidents monthly, to identify any trends. They said the analysis had led to a change in staffing levels and training, as well as amendments to staff techniques and people's medicines.

Meetings had been arranged for people and their relatives to give their views about the home. However, these had not been recent and feedback about them was limited. For example, one person told us, "There are meetings. I don't think we've had one for a long time and I can't remember much about them when we did have them." Another person said, "I think we do have meetings but I can't remember when it was and they change things without telling you sometimes, I think we should be involved." Two relatives told they had been sent feedback questionnaires to complete. One relative told us, "I fill in forms if they're important, and I'm pretty happy with everything here and talk to staff if I'm not, so I probably wouldn't have done it."

They said they were giving time to stabilising the home before taking on new admissions.