Pilgrim Homes

Pilgrim Homes - Milward House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 16 and 23 February 2015 and was unannounced.

Pilgrim Homes - Milward House is a care home providing accommodation with nursing and personal care for up to twenty eight older people who are practicing Christians, some of whom were living with dementia. The service is located in Tunbridge Wells, approximately half a mile from the town centre. The service was provided in a large detached property with accommodation on two floors in the main building. There was independent living accommodation attached to the property. This part of the service does not require registration with the Care Quality Commission. People had a variety of complex needs including dementia, mental and physical health needs and mobility difficulties. The last inspection was carried out on 2 February 2014 when we found the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were met.

Summary of findings

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which cam into force on 1 April 2015. People were not safeguarded against abuse. Some staff were not adequately trained to meet people's needs. People did not receive personalised care in accordance with their wishes and choices.

There was a registered manager at the service. 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.

People gave us complimentary comments about the service they received. People felt safe and well looked after. Our own observations and the records we looked at did not consistently match the positive descriptions people and relatives had given us.

We observed unsafe practice which placed people at risk of harm because staff did not follow correct procedures. The provider had not taken adequate steps to make sure that people were safeguarded from abuse and protect them from risk of harm. People from the independent living units and anyone visiting them had unrestricted access in and out of the service through connecting doors on upper floors which were not locked. There were no assessments of the risks this presented to the people living at the service or evidence of consultation with them about this arrangement. Management and quality assurance systems were not consistently effective in recognising shortfalls so that necessary improvements were made for people to receive a good service.

People's care plans did not provide staff with the information they needed to provide a personalised service. People's choices were not respected in relation to receiving personal care from staff of the same gender. Not all staff were trained in the Mental Capacity Act 2005 (MCA) and DoLS to make sure they knew how to protect people's rights. People were asked for their consent before staff carried out care or treatment. People were involved as far as possible in their assessments and action to minimise risk was agreed with them. Some staff had not received all the essential training and updates to enable them to carry out their roles effectively.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, the registered manager had submitted some applications to the local authority and was aware of the Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these had been authorised by the local authority as being required to protect the person from harm.

Safe recruitment procedures ensured that staff were suitable to work with people. Staff received regular supervision, support and appraisals to monitor and assess their work and performance. Regular staff meetings were held to make sure staff were kept up to date with any changes in the service and had opportunities to make suggestions or raise concerns. The provider had a whistle-blower policy which staff were aware of.

People's nutrition needs were assessed and their weight was monitored to make sure they were getting the right amount to eat and drink to protect them from the risk of malnutrition. Most people told us they enjoyed the meals provided. Staff made sure that people's dietary needs were catered for. People received the medicines they needed when they needed them. People were supported to manage their health care needs by the nurses. Advice from other health professionals was followed to make sure people's health was promoted. Prompt action was taken when people showed signs of illness.

Most staff were respectful, kind, caring and patient in their approach and had a good rapport with people. People knew who to talk to if they had a complaint. Complaints were passed on to the manager and recorded to make sure prompt action was taken and lessons were learned which led to improvement in the service.

People were able to choose from a range of activities to promote their wellbeing, although there were no personalised programmes of activity for people living

Summary of findings

with dementia or those who were nursed in bed. Christian based activities were provided daily to ensure people's spiritual needs were met. People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and people were able to spend time with family or friends in their own rooms and other areas.

The attitudes, values and behaviours of staff and the management enabled and encouraged open communication with people and their relatives. We received mainly positive feedback from people and their relatives about the service. Quarterly satisfaction surveys and meetings were used to obtain the views of people and their relatives about the service and inform improvement plans.

Records relating to people's care and the management of the service were well organised and kept up to date.

We recommend that an up to date analysis of the level of support people, including visitors from the adjacent supported living flats, need is maintained and used to determine the number of staff needed on each shift.

We recommend that the providers consider the use of the service by those who are not receiving care or treatment and the impact this has on the care and safety of those that are receiving the service.

We recommend that improvements are made in quality assurance systems to reflect published research and guidance.

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?

Inadequate 

The service was not safe

Staff did not consistently follow correct procedures to protect people from risk of infection or injury. People were at risk because the provider had not ensured the security of the premises.

The numbers of staff deployed did not take account of the support provided to visitors from the adjacent supported living service, to ensure there were enough staff at all times.

The provider operated safe recruitment procedures to make sure staff were suitable to work with people.

People received their medicines when they needed them. They were protected against risk of malnutrition and dehydration.

Is the service effective?

Requires Improvement 

The service was not consistently effective

The provider met the requirements of the Deprivation of Liberty Safeguards. There were procedures in place in relation to the Mental Capacity Act 2005 to ensure that people's rights were protected.

Some staff had not received all the essential training and updates required to enable them to carry out their roles effectively. Staff received the supervision and support they needed.

People were supported effectively with their health care needs.

People's weights were monitored and recorded regularly. Staff had the knowledge and skills to make sure people were getting enough to eat and drink.

Is the service caring?

Requires Improvement 

The service was not consistently caring

People's diversity and choices were not always respected because their requests in respect of the gender of care staff providing personal care were not taken into account.

Some staff did not communicate with people when carrying out care tasks. Most staff were respectful, kind, caring and patient in their approach and supported people in a calm and relaxed manner.

People were involved in planning their care and their privacy and dignity was protected.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not individualised so that staff had the information they needed to provide a personalised service. Pre admission assessments were robust to ensure people's needs could be met.

People were supported to take part in activities although there was no personalised programme for people living with dementia or those nursed in bed. People were supported to maintain their relationships with people who mattered to them.

Complaints were managed effectively to make sure they were responded to appropriately in a timely manner, investigated and any learning was identified and incorporated into improving the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not effective in recognising some shortfalls in the service which impacted the quality or safety of service people received. Where shortfalls were identified, action and improvements plans were developed and any necessary action was taken.

The attitudes, values and behaviours of staff and the management did not consistently demonstrate the vision and values of the service.

Records relating to people's care and the management of the service were well organised and maintained.

Pilgrim Homes - Milward House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 23 February 2015 and was unannounced.

The inspection team included three inspectors and an expert-by-experience who had personal experience of caring for older family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority and previous reports. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about. We looked at information staff had sent us about the service.

We would normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks for some key information about the service, what the service does well and improvements they plan to make. However, this inspection was planned in response to a concern we had received and there was not time to expect the provider to complete this information and return it to us. We gathered this key information during the inspection process.

We 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 examined records including 5 people's individual care records, 5 staff files, staff rotas and the staff training schedule. We sampled policies and procedures and audits of aspects of the service. We looked around the premises and spoke with 14 people, six relatives, the registered manager, two nurses, four care staff and a volunteer.

The last full inspection was carried out 2 February 2014 when we found the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were met.

Is the service safe?

Our findings

People gave us complimentary comments about the service they received. People told us they felt safe and said, "'Very safe. If I hear a noise here, I don't have to worry about it, unlike at home", "It's all safe here", "It's all very clean here" and "They clean my room every day".

Relatives told us they felt that their loved ones were safe. They said "We've never had any reason to think otherwise", "Oh, yes, very safe" and "it's always very clean, and doesn't smell here at all'. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

We observed incidents of unsafe practice which placed people at risk of harm. The provider had provided training for staff in moving and handling, but staff did not consistently follow correct procedures. Staff did not follow safe practice for moving a person using a hoist. There were two staff in attendance. One member of staff was new and was observing the hoisting. The person was crying out as they were lifted. One leg of the sling was not attached and the person was in an uncomfortable position, slipping down. This was not noticed by staff who continued to lift the person until we intervened. A second staff member attended and they attached the sling and lifted them again. The person was safer, but did not look comfortable. The staff asked the person if they were ok and they said, "just about". We reported this incident to the manager and to the local authority safeguarding team. The manager showed us that staff had been booked on refresher courses for moving and handling immediately following the first day of our inspection.

People were not protected against the risk of receiving unsafe care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had provided training for staff in infection control, people were at risk of infection because staff did not consistently follow safe practice. Staff were able to describe the correct procedure for dealing with soiled laundry using red bags. Red alginate bags are dissolvable and should be used because soiled laundry can be placed in them and sealed at the point of origin. The bags are then placed directly into a washing machine without the need for further handling. We observed staff carrying soiled linen in a black bin liner through the premises. They said the red bags were in the laundry and they did not know why they had not used them. Soiled laundry was stored in an open laundry bin in open black bags in a bathroom which people used. Another member of staff carried contaminated laundry through the home without any bag. At lunchtime, staff who were supporting people in the dining room did not always put on the apron from the dispenser straight away before they started serving food. Staff walked around the home wearing protective gloves after supporting people with their personal hygiene. The registered manager removed the laundry bin from the bathroom during our inspection and showed us they had arranged refresher courses for staff in infection control.

There were policies and procedure in place to minimise the risk of infection, but the system for auditing was not sufficiently robust. The registered manager told us there was an infection control lead nurse and an audit was carried out once a year. We found some areas of the home were not clean. The radiator cover in the dining room was water damaged and the wood was raised and the paint was chipping. The material had become porous and could not be cleaned effectively. The bathroom on the third floor had 3 bins in the corner. We spoke to the registered manager who told us that one was a linen bin and two appeared to be waste bins however they all had black bin liners inside them and none were pedal operated. Clean bed linen was stored in unlocked cupboards in bathrooms. The sluice room floor was not clean. A person's urine bottles were kept within people's reach in a bathroom and there were unpleasant odours in several areas. There was a slipper bed pan, on the floor in a downstairs toilet.

People were not protected from the risk of infection. The examples above were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not taken adequate steps to protect people from abuse and the risk of abuse. There were two unlocked doors above ground floor level which connected the main house with the independent living units (ILU). We observed people from the independent living units coming

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freely in and out through these doors. This meant that there was no way of knowing who was in the service or ensuring that people and their belongings were secure. The manager told us that unrestricted access had always been given to people who lived in the independent living units. Many of them came into the service for meals and activities or to sit in the lounge. Before our inspection the provider notified us of 2 occasions when a person from ILU had been verbally and physically abusive to people at the service.

The staff training schedule showed that most of the staff were not trained in safeguarding adults. Staff understood what was meant by abuse and knew how to report abuse within the organisation although they were not clear about reporting to external agencies. There was a safeguarding policy and a copy of the Local Authority Safeguarding Adults policy at the service for staff to refer to if guidance was required.

The examples above showed that people were not protected from the risk of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were based on an overall analysis of the levels of support people who lived at the service needed. However there had been no assessment of the time spent by staff supporting people who visited the house from the independent living units to make sure people were safe. Relatives said, "I think sometimes they are stretched", "They have been a bit short-staffed recently" and "Staff can be a bit sparse at weekends." There were six permanent nurses, one bank nurse and, 33 care workers and seven bank care workers. There was also a group of volunteers who supported the service. Staff said they had enough staff on duty to meet people's needs. They confirmed that they did not provide any personal care to people who lived in the independent living units, but they did serve their meals and talk with them when they came to the dining room for meals or joined in with daily activities. This meant that staff were taking time away from supporting the people who required their care. There was not always a member of staff in the lounge although it was easy to find staff if they were needed.

Visitors who came into the service through the main door signed in and out of the building. People who came from the independent living units through the other connecting doors did not sign in and out so there was no way of knowing how many people were in the service in the event of an emergency such as fire. We discussed this with the registered manager. Following the first day of our inspection the registered manager told us that people from the independent living units had been asked to sign the visitor's book whenever they came into the main house so that in the event of a fire accurate records were available.

The provider operated safe recruitment procedures. Staff files included completed application forms, which had staff members' educational and work histories and a health declaration to show they were fit to provide care for people. There was a system in place to make sure staff were not able to work at the service until the necessary checks had been received to confirm that they were suitable to work with people. Individual staff files included references and proof of identity. There was evidence that disclosure and barring service (DBS) checks had been carried out. These checks help providers to make safer recruitment decisions.

People were given their medicines as prescribed and intended by their doctor. Some people were prescribed medicines, including sedatives or pain relief medicines 'to be taken as required'. There was individual guidance for all the people to whom this applied for staff to follow. This made sure a consistent approach was taken in deciding when to offer the medicines.

Records showed that medicines were received, disposed of, and administered safely. People's individual medicine administration records for prescribed medicines were completed accurately. Medicines were stored securely. One person described how they managed their own non-prescription medicines, "I have a secure box". Suitable arrangements were in place for obtaining medicines. Records of medicines received were maintained. This meant that medicines were available to administer to people as prescribed by their doctor. Nurses administered medicines to people and they did so in a safe way, making sure people had taken their medicine before they moved on to the next person.

The environment was kept free from hazards. A maintenance officer was employed for general maintenance of the building. Safety checks were carried out at regular intervals on all equipment and installations. There were systems in place to make sure people were protected in the event of a fire. However, this system had not been used to consider how many people would be in

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the building at any given time. Instructions were displayed throughout the home concerning what actions staff should take in case of a fire. There was suitable equipment in place such as extinguishers. Fire exits were clearly marked and accessible. The maintenance officer was trained in health and safety and fire safety and had carried out a fire safety risk assessment to make sure the premises were safe.

We recommend that an up to date analysis of the level of support people, including visitors from the adjacent supported living flats, need is maintained and used to determine the number of staff needed on each shift.

Requires Improvement

Is the service effective?

Our findings

People told us staff were competent. They said staff were, "Excellent and expert", "They are very good, they do what they can", "I find all of the staff are very good here. Competent" and "Some people say things are not done right, but I think they are very good". Relatives and visitors praised the staff. They said, "Always found the staff helpful" and "They know what they are about".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No-one living at the home was currently subject to a DoLS restriction. The manager understood when an application should be made and had made some applications to the local authority. The manager carried out best interest meetings when decisions were required on behalf of people who were not able to make important decisions for themselves.

There were procedures in place and guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. We observed staff obtaining people's consent before providing support. Staff had a good understanding of MCA and talked about how people's capacity changed on a daily basis and in relation to different decisions.

A staff member moved a table away from a person sitting in an armchair once they had finished their meal. They told the new member of staff who was shadowing them that this was to enable them to move freely and prevent them being restrained.

The staff training schedule showed that staff did not have all the essential training they needed to ensure they understood how to provide effective care, and support for people. There were gaps in the training schedule which showed that 14 out of 41 staff had completed safeguarding training. None of the staff had training in how to care for people who presented behaviours which placed themselves or others at risk of harm. Two members of staff had attended Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. Most staff had dementia awareness training and staff were not provided with training in how to care for people experiencing hearing or sight impairment. The staff were caring for people living with dementia and who experienced sight and hearing loss without the training they needed. Some additional training was provided in topics such as osteoarthritis and stroke.

Thirty eight percent of staff had completed National Vocational Qualification awards in health and social care. National Vocational Qualifications (NVQs) are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability (competence) to carry out their job to the required standard. Nurses were supported to maintain their professional registration through regular training opportunities.

The examples above showed the provider had not ensured that staff received appropriate training to meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Staff were provided with support to carry out their roles. Staff told us they felt well supported and had personal supervision every few months. Each member of staff had an annual appraisal in which their performance was assessed and any training needs were identified. Appraisals were a two stage process where the staff member appraised themselves first and then met with their manager to discuss their appraisal. Appraisals included professional abilities and personal qualities and allowed staff to monitor their own work performance and for their managers to set the expected standard of work.

People were protected against the risk of dehydration or malnutrition. There were mixed views about meals. People told us, "They could do better, particularly with tea. There's not much choice and they find it difficult to keep the soup hot", "Breakfast is always the same", "I eat what I can" and "There's no choice, but I don't mind". Other people said, "Excellent, I just eat it", "I have enough with the three meals. They would find me something else if I wanted", "I think it is very good food", "I never wanted a choice. I am just thankful for food". Everyone said there was sufficient and commented on the 'home made cakes' and fresh fruit. There was a choice of cold drinks available in the main lounge.

Requires Improvement

Is the service effective?

During lunch people in the dining room were shown cranberry or orange drinks to choose from and there were water jugs on the tables. There was a choice of either 'sausage toad', or veggie sausages. Staff told us that a set meal was offered each day unless you were vegetarian and you could then have another option. Vegetables and gravy jugs were brought to each table. Some people served the vegetables to other people on each table and some people helped themselves. Staff knew the people who only liked a small portion..

Ten people from the independent living units came for their meals each day in the dining room. There was not enough space in the dining room to accommodate people who lived at the service and 10 additional people. Several people ate their meals in the lounge. The manager told us this was because they had found these people ate better in quieter surroundings. The people in the lounge were not offered a choice of where they wanted to eat their meals each day and there was no record of any consultation about this in their care plans.

People who ate in the lounge sat in their armchairs with a small table in front of them. They were not given a choice of meal or portion size. Those who finished were not offered seconds. One person was struggling to reach their plate and was consequently spilling food into their lap. People had aprons on. This aspect of the care requires improvement.

We observed staff encouraging people to drink throughout our inspection. People's weights were monitored to make sure they were getting the right amount to eat and drink. Staff who were helping people who ate in the lounge to eat their lunch did not rush them. They gave them time to enjoy their meal.

People told us they saw a doctor when they needed too. They said, "A doctor comes here regularly and I had a physio for a time but that's stopped now" and "They ring through to the doctor and she comes". People told us how well the nurses looked after them and checked their blood pressure. A relative described what happened when a person looked unwell, "The nurse took her temperature and blood pressure, then again later, and then called the doctor who came the same day". Records showed that people were referred to health professionals including GP's, community psychiatric nurses, chiropodists and dieticians for support with their healthcare needs. People's care plans were updated to show contact with and advice from health professionals.

Requires Improvement

Is the service caring?

Our findings

People told us they were well cared for. They said, "Wonderfully well looked after" and "Staff are good and caring". One person described staff as "approachable". Relatives commented on how polite the staff were. A relative told us how pleased they were that "Staff joke around with her, just like we do".

Some staff were more aware of people's needs that others. This was evident during lunch time. One member of staff came into the lounge and cleared people's drinks from their small tables without checking with them if they had finished. Another member of staff had to keep getting up and leaving a person they were helping to eat to serve food to other people. This aspect of the service requires improvement.

Most staff engaged with people positively. They took time to chat with people and were kind, caring and patient in their approach. We observed people being supported to move around the home. Staff went at the pace of the person and chatted with them as they walked. There were lots of smiles and warmth in conversations and interactions we observed throughout our inspection.

People could not remember being involved in planning their care. Care plans or reviews were not signed by the person concerned or their relatives to show their involvement. Most of the staff knew people well. They were able to describe the approach they used with a person who often refused personal care. They said they would offer again at a different time or try a different carer as that sometimes helped the person. There were memory boxes situated outside people's bedrooms to help people to locate their own rooms. Staff were able to tell us about why people had chosen the items they wanted to have in there, for example photos of pets, an interest in buses and a background in farming. Most people had personalised their bedrooms with their own belongings which reflected their likes and interests, such as ornaments, photographs and pictures.

Staff were careful to protect people's privacy and dignity by being discreet in their conversations with one another and with people who were in communal areas of the home. Staff made sure that doors were closed when personal care was given. Any treatments people needed were carried out in private. We saw staff knock on people's doors before entering their rooms. Staff made sure that people's personal information was treated confidentially and any personal records were stored securely to make sure people's privacy was respected.

People were supported to remain as independent as possible. Staff knew what people could do for themselves and encouraged them to continue to do those things. Where people needed some support with daily activities staff did not take over. They made sure people had the right utensils to enable them to continue to eat and drink by themselves or with minimal support.

People who were able to, continued with their previous interests and maintained contact with friends and family. Relatives were aware they could visit at any time. They told us there were no restrictions on visiting, were always made welcome and there were several places to go for private time with their family member. Relatives told us, "We take her out to the park in summer. They encourage it" and "We are welcome anytime, we have the door code, and can make tea". A visitor told us that relatives could stay for lunch if they booked it.

People's spiritual needs were met in a caring way in accordance with the stated aims of the provider which was to provide care for older Christians. Daily services took place in the lounge and a variety of visiting speakers from local churches visited to give talks. Volunteers from local churches visited people to pray and talk with them when invited to do so. One person said, "I like the morning service. We have different ones at different times".

Requires Improvement

Is the service responsive?

Our findings

People had mixed views about the responsiveness of the service. They said, "I don't think they are used to having partially sighted people here. They do try, but I wish they could see what was needed more, so I didn't have to ask". They said that staff tried to help but were "Not always getting it right yet". Other people gave examples of how the service had been responsive. One person had asked not to be woken up too early, "And now they don't. And, in the night, I'm not disturbed now". Another person said, "I prefer my breakfast upstairs, before I get dressed to come down, and this is fine".

Routines in the home were not always flexible to accommodate people's individual choices. People told us there was not much choice about when they could have a bath or a shower. There was a bath rota which allotted a set time each week. The day people had a bath was recorded in their care plan staff were not instructed to offer baths at other times. Staff confirmed people would not be able to choose to have a bath more frequently as there would be insufficient time to allow this.

People's diversity and values were not always respected. People's views about who supported them with their personal care were not taken into account when shifts were planned. There was a mix of male and female care staff on duty during our inspection. Male care staff assisted women with their personal hygiene needs. One person's care plan stated that they would prefer female care staff to support them with their personal care but this was ignored. One of the male care staff told us there was, "A list" of people who would prefer not to have a man supporting them but could not explain why he had not taken note of this. The person told us they, "I would prefer a lady but that's what it's like here".

Staff told us that three people were supported each day into bed after handover, between 2pm and 3pm. They said this was for a change of position for pressure relieving but they also said that they were washed and dressed for bed at this time and they then remained there until morning, having supper in bed where they were more comfortable. There was evidence in one person's care plan that their relatives had been consulted about them going for bed rest in the afternoon, but it was not clear in the records that it was agreed they would remain there.

Two male care staff worked together in the afternoon. They provided personal care to the three women who went to bed in the afternoon. The three women were living with dementia, and unable to verbalise their views about their personal care. Most care plans did not show that people had been asked about their preferences and the two male care staff did not ask people if they would prefer a female member of staff before providing their care.

Staff said that most people went to bed after supper at 5pm with two or three people staying up until the night staff came on duty. Care plans did not have any information about people's preferred daily routines. One person told us they did not want their lunch at 12:00 as this was too early. They told us they had raised this with the manager, but had not been offered their meal later in the day.

An assessment of people's needs was carried out before they moved to the service to make sure it would be suitable for them. Relatives were also involved in the assessment to support their family member and provide additional information about the person. Each person had a care plan. These were not personalised. They were based on tasks such as personal care requirements and did not reflect the person's views about things that were important to them. There was a lack of information in the plans to guide staff in meeting people's social needs and ensuring they were not isolated or lonely.

One person's care plan stated they were to be involved in all activities in the service however they were returned to bed in the afternoon so would not have been able to participate. The plan referred to the activities worker doing some 1-1 work with the person but staff were unable to find any records to show this and were not aware of any sessions carried out. The care plan did not provide staff with any information on how to reduce isolation or loneliness for the person when in their bedroom for the majority of the time in a 24 hour period. Staff told us they popped in to provide drinks and personal care.

People living with dementia and those who were nursed in bed did not have individual activity programmes to promote their wellbeing. Those who were not independently mobile did not have objects within reach for them to look at or interact with. There was a weekly activity programme which included, 'ball games, exercise to music and ludo'. The 'hobbies room' contained a large number of books and jigsaws and a few other activities. There were no

Requires Improvement

Is the service responsive?

chairs for people to sit at the table in the hobbies room. The manager explained that this was because they had been moved into the lounge for people to use during the morning devotional activity. There were no activities left out on the table for people to access if they wanted to.

Although there was detailed written information in people's records and life story books this was not used to plan meaningful activities or meet people's social needs. People told us there was a part-time member of staff who arranged some activities. A member of care staff was helping some people in the lounge to complete a crossword. People said, "There's nothing much to do, but sometimes things in the afternoons, like quizzes. I like that", "Quite a bit going on. And when I don't want company, there's my room", "There are things to do in the afternoons, but I like to sleep" and "There's weekly scrabble and other things in the afternoons".

The examples above showed the provider was not providing a personalised service in accordance with people's wishes and choices. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to join in the daily service and enjoyed singing the hymns they were familiar with. One family told us, "We've been asked to bring in a photo album, so the staff can look at it with her". Themes in accordance with the Christian calendar were incorporated into activities throughout the year. People told us, "They remembered 'St Patrick's day, Remembrance day, Eastertime, and so on, it's all decorated".

People knew who to talk to if they were unhappy about any aspect of the service. People said they did not have any complaints, "Just little niggles from time to time". People told us they would not hesitate to say something. They gave examples of concerns they had raised which had been addressed. One person said, "You can't live in a community and not give a bit. But if there are any little things not done, I only have to ask, or I go to the Manager and we talk it over. There was too much loud music. They listened, and it was sorted out". There was a complaints procedure on the notice board. This gave information about who to make a complaint to and how the complaint would be handled. There was also information about external agencies who people could make a complaint to if they were not happy with how it had been handled at the service. Records were kept of verbal and written complaints. These showed that complaints had been responded to in a timely manner.

Is the service well-led?

Our findings

People told us they were generally satisfied with the service they received and were very pleased with the Christian ethos. In addition to the daily and other services, other things were mentioned. People said, "The manager will pray with you, which is wonderful", "It's as much like home as it can be". A relative laughingly said, "She now says she chose a good home, but she didn't really. We did". One person mentioned a memorial service for a recently deceased resident, which was, "A joy". Everyone knew the registered manager by name.

Systems to regularly assess and monitor the quality of the service were in place. These were not effective in identifying shortfalls and identifying and managing risks to make sure people were safe and their wellbeing was promoted. We found that people were at risk of harm because infection control practices and hygiene standards were not monitored effectively. The open door policy for people who lived in the independent living units meant that people had to share communal areas with other people who did not live at the service and were placed at risk of harm. Care planning was not effective in making sure people received a personalised service. People living with dementia were not provided with meaningful activities or consistently supported by staff who understood their needs. People's diversity, values and wishes were not respected when personal care was provided. We have made recommendations related to this aspect of the care and service.

The registered manager had responsibility for quality assurance and carried out regular audits of all aspects. The operations manager carried out an annual review. Action plans were drawn up following audits and reviews which included timescales within which improvements would be made. An annual development plan was in place. This showed that the provider had recognised that problems with staff recruitment and the high turnover of staff had impacted on the service and was actively seeking to recruit additional permanent staff. They had recognised that improvement was needed in the service for people living with dementia. They had sourced more in depth training for staff to be undertaken in 2015. There were also plans to carry out refurbishment work in areas of the building.

The registered manager had undertaken a 'My Home Life course'. The registered manager told us they had begun to pass on this knowledge and the reflections on the challenges brought out of Mattering training in staff meetings. We found that this approach had not yet been embedded into practice during this inspection. Staff were focussed on carrying out tasks for people rather than working with them and making sure they received a personalised service in accordance with their wishes and choices. The Manager was about to undertake a Dementia Care Matters course which is about providing a personalised approach to caring and providing activities for people who were living with dementia.

The deputy manager and the registered manager oversaw the day to day management of the service. They knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the provider who provided all necessary resources to ensure the effective operation of the service. Senior staff and care staff were accountable to the nurse on duty on each shift. Staff understood their roles and responsibilities and told us they worked well as a team.

Staff said that they were happy to approach the manager if they had any concerns and that suggestions were taken on board. One staff said they had made suggestions about personalising people's bedrooms more with photographs and that this had happened. A volunteer told us, "'All of the staff here are helpful, friendly and caring, I've always found this. This is due to the 'good manager".

There were processes for gaining the views of people who used the service. These included quarterly resident's meetings and questionnaires on aspects of the service. The management had day to day contact with people and their relatives who knew they could talk with the management at any time. Resident's meetings were focussed on specific aspects of the service. Hand-outs were provided on topics of interest to generate discussion with people and their relatives and to provide them with information, for example about living with dementia. The manager told us they recognised the need for more general meetings and would be introducing meetings where people could raise and discuss issues that were important to them.

The attitudes, values and behaviours of staff and the management mostly enabled and encouraged open communication with people and their relatives and with one another. However, we saw examples of practice, such as an incident of poor moving and handling and disrupted

Is the service well-led?

meals. This area of the service requires improvement. The induction training programme for new staff covered the aims and values of the service to make sure staff understood and worked in accordance with them. The staff and management team worked well together, supporting each other whenever help was needed. They were consistently friendly and cheerful, creating a warm and welcoming atmosphere where people were able to feel 'at home'.

The management team understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) in that they submitted notifications to us in a timely manner about any events or incidents they were required by law to tell us about. Records relating to the management of the service and people's nursing needs were well organised and up to date. This meant that staff and others had access to reliable information to enable them to provide the nursing care people needed.

We recommend that improvements are made in quality assurance systems to reflect published research and guidance.

We recommend that the providers consider the use of the service by those who are not receiving care or treatment and the impact this has on the care and safety of those that are receiving the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not have suitable arrangements to ensure that staff were appropriately supported by providing appropriate training.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not protected against risks of inappropriate or unsafe care and treatment, because the assessment of needs and planning and delivery of care did not ensure their welfare and safety. The planning and delivery of care did not reflect published research evidence and guidance in relation to people with dementia and other conditions.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who use services were not protected against the risks of neglect and acts of omission that cause harm or place at risk of harm.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected from the risk of infection.**

This section is primarily information for the provider

Enforcement actions

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