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Dean House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 September 2016 and was unannounced.

Dean House is a residential care home providing accommodation, including respite care, for up to 27 people, some of whom are living with dementia or diabetes and who may require support with their personal care needs. On the day of our inspection there were 21 people living at the home. The home is a large property situated in East Preston, West Sussex. It has a communal lounge, dining room, conservatory and garden.

The home was the only home owned by the two providers and the management team consisted of a registered manager, an operations manager and a team leader. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

People had variable experiences and we found several areas of practice that required improvement.

There were concerns with regards to people's emotional and social needs being met. People told us that staff did not have time to spend with them and our observations confirmed this. Observations showed staff were very busy and task orientated and did not appear to make time to meet people's social and emotional needs. One person told us, "There are enough of them but they are very busy, sometimes when you ask them something they are a little abrupt but it is just because they're busy". Another person told us, "The staff don't have time to be friendly".

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People provided mixed feedback with regards to the provision of activities. Some people told us that they enjoyed the external activities that were sometimes provided, however, felt that there wasn't much to do to occupy their time and our observations confirmed this. People who spent time in their rooms were at risk of social isolation. Observations showed people spending extended periods of time alone in their rooms, only seeing staff when they were providing personal care or food and drink. One person told us, "There is not much to do here". Another person told us, "I don't get visitors', I have no family, I get incredibly lonely, the only criticism I have is the boredom". A relative told us, "There is not enough to occupy them, I feel a bit more one to one time with my relative could be an improvement".

People's health and physical needs were assessed when they moved into the home, these were reviewed on a monthly basis by care staff. However, there were concerns regarding the involvement of people and their relatives' in the care plan reviews. One person told us, "I know I have a care plan but I've not had a review". A relative told us, "I've not experienced a review in the last twelve months and I've never been informed of the outcome of an assessment my relative had some time ago, communication from the home is somewhat lacking". Care plans did not contain sufficient information about people's life history, background or social and emotional needs. The management team had recognised this and were in the process of developing a new care planning system, which was yet to be implemented, to address this. Reviews that did take place

did not always reflect the good practice carried out by staff. For example, one person's review failed to recognise that the person had been referred by the registered manager to a healthcare professional and that their support needs had changed. Observations showed that staff had implemented the necessary changes but this had not been sufficiently documented to ensure that the person's care was consistent.

The lack of interaction and stimulation for people, as well the lack of involvement of people and their relatives' to ensure person-centred care was provided are areas of concern.

People's consent was gained and staff respected people's right to make decisions and be involved in their day to day care. The registered manager was aware of the legal requirements with regards to ensuring people who lacked capacity were not deprived of their liberty unlawfully. However, had not ensured that these were in place for all people who lacked capacity. For example, three people, who used bed rails and who lacked capacity to consent to their use, had not had their capacity assessed, nor had their legal representatives been involved in the decision making process to consent to their use. This is an area of concern.

People were happy with the choice, quality and quantity of food and had a positive dining experience. Most people had access to fluids and snacks throughout the day. However, for people who spent time in their rooms or who needed additional assistance to eat and drink, there were concerns regarding their intake of fluid. Food and fluid charts were implemented for people to enable staff to monitor their levels of intake, however, these were not always maintained, completed accurately nor monitored. Observations raised further concerns regarding some people's fluid intake. For example, one person had two drinks left beside their bed, they were unable to reach their drinks and these were simply taken away two hours later. This is an area of concern.

Quality assurance systems were neither effective nor documented to enable the registered manager to have sufficient oversight and awareness of all of the systems and processes within the home. For example, audits that had been conducted had not recognised that some records and reviews had not been sufficiently completed. Records were not always completed sufficiently and this raised concerns over the care that people had received. The lack of quality assurance systems and the maintenance of records are areas of concern.

There were effective systems in place for the storage and disposal of medicines and people told us that they were happy with the support they received. One person told us, "I do get tablets morning and evening and they do see me take them". Another person told us, "Yes, I do get my medication when I expect it, they trust me to take my medication". However, there were concerns regarding the management of medicines. Some medicines, such as liquid medicines and creams, have a limited shelf life. Observations showed that several medicines, which had a limited shelf life, had been opened and no dates had been recorded on the containers to inform staff of how long the medicines had been in use. Therefore people were at risk of receiving out of date medicines that may be less effective or cause them harm. This is an area in need of improvement.

People and relatives' provided mixed feedback about the cleanliness of the home and our observations raised concerns regarding the standard of cleaning. Observations showed that not all areas of the home were hygienically clean. Ceilings in two rooms, one of which was used by people, were covered in cobwebs, spiders and insects. When this was raised with the registered manager, they told us that they had not noticed this and would ensure that these were removed the following day. Some doors, handrails, banisters and floors were visibly soiled and sticky to the touch, as were some people's own bathrooms and washing facilities. Results of a recent resident quality assurance survey contained comments from a person about

their room, it stated, 'On the odd occasion there has been food debris, stickiness and stains and the bin has not been emptied'. Observations showed that at certain times in the day there were strong, offensive smells within the home. Results of a recent relative quality assurance survey contained comments such as, 'Not always odour free' and 'On the whole it is clean, although my relative's room not always. It gets smelly at times and the bathroom gets neglected'. Not maintaining effective infection control could potentially have meant that people were at risk of developing and spreading infections and did not contribute to a homely and pleasant environment for people to live. This is an area of practice in need of improvement.

People were encouraged to be independent and undertake positive risks. Risk assessments had been completed to identify environmental risk as well as some risks that were specific to people's needs. For example, a risk assessment had been completed for someone who chose to smoke. However, risk assessments in relation to social isolation and people's emotional and behavioural needs were not completed. This is an area of practice in need of improvement.

There were sufficient numbers of staff to ensure that people's care needs were met and that they received support promptly. Staff had a good understanding of safeguarding and people told us that they felt safe. Although the registered manager had informed us of some events and incidents in the home, they had had not informed CQC of two safeguarding investigations that had been conducted by the local authority. This is part of the registered person's responsibilities. By not being informed of these incidents CQC were potentially unable to ensure that the appropriate actions had been taken to ensure that people were safe. This is an area of practice in need of improvement.

Staff were suitably qualified, skilled and experienced to ensure that they understood people's needs and conditions. Essential training, as well as additional training to meet people's specific needs, had been undertaken. People told us that they felt comfortable with the support provided by staff. When asked if they thought staff had the relevant skills to meet their needs, one person told us, "Oh yes, the staff are good at what they do".

People's healthcare needs were met. People were able to have access to healthcare professionals' and medicines when they were unwell and relevant referrals had been made to ensure people received appropriate support from external healthcare services. One relative told us, "They reacted quickly last week to my relative being sick by calling the doctor".

Positive relationships had been developed between people as well as between people and staff. There was a relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People's privacy and dignity were respected and maintained, one person told us, "The staff are kind and respectful. They knock on my door before coming in". People were encouraged and able to make complaints about their care, however, told us that this was something that they had not felt the need to do. One person told us, "No, I've not needed to complain, but I would".

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

Sufficient numbers of staff ensured people's safety. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People received their medicines on time, these were dispensed by trained staff. However, there were concerns regarding the management of some medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks. However, there were concerns regarding the cleanliness of some areas of the home.

Is the service effective?

Requires Improvement

The home was not consistently effective.

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

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience. However, there were concerns regarding sufficient fluid intake for some people.

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

Is the service caring?

Good

The home was caring.

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

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

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

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

There was a lack of meaningful activities for people to participate in and some people were at risk of social isolation.

Care plans documented people's individual health needs. However, sometimes lacked information about people's social and emotional needs.

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

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes did not sufficiently monitor practice to ensure the delivery of high quality care and to drive improvement. Records were not always completed consistently and therefore it was not clear if people's care needs had been sufficiently met.

People and staff were positive about the management and culture of the home. However, the registered manager had not always notified CQC of some events and incidents that affected people.

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

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

The inspection took place on 5 September 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of home. Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

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

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

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that the home was a safe place to live. One person told us "I've had no safety problems here". Another person told us "I feel fairly safe, I need a walker to move around with". Whilst a third person told us, "The staff do treat me well". However, despite these positive comments we found areas of practice in need of improvement.

People's individual needs were assessed and reviewed each month and this was used to inform the staffing levels. Staff told us that there were enough staff and that staffing levels were increased if people were unwell or needed additional support, for example, if they were at the end of their life. However, results within a recent staff quality assurance survey contained comments such as, 'More staff on duty when we have service users' that are in need of more care and attention' and 'More staff, more flexibility to cover when there is sickness'. The management team had responded to staff's feedback and had recruited more ancillary staff to ensure that care staff could spend more time with people. People told us that they felt that there were enough staff to meet their care needs.

People were assisted to take their medicines by trained staff that had their competence assessed. Safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People told us that they were happy with the support received. One person told us "Yes, I do get my medication when I expect it, they trust me to take my medication".

Some medicines can be less effective or harmful if they are out of date. Some liquid medicines and creams have a limited shelf life once they are opened. Observations showed that the date of opening had not been recorded on creams that were stored in people's rooms. For example, prescribed creams for several people, which had limited shelf lives once opened, had not been marked with the date of opening. This meant that people may have been given out of date medicine as there was no system to check that medicines were still in date. This is an area of practice in need of improvement.

The Department of Health guidance: Prevention and control of infection in care homes – an information resource, states that, 'Good infection prevention and control are essential to ensure that people who use health and social care services receive clean safe care and must be a part of everyday practice and applied consistently by everyone'. The registered manager had devised cleaning schedules to ensure that most parts of the home were clean and presentable and most people told us that they felt that the home was clean. However, observations showed that not all areas of the home were hygienically clean. Ceilings in two rooms, one of which was used by people, were covered in cobwebs, spiders and insects. When this was raised with

the registered manager, they told us that they had not noticed this and would ensure that these were removed the following day. Some doors, handrails, banisters and floors were visibly soiled and sticky to the touch, as were some people's own bathrooms and washing facilities. Results of a recent resident quality assurance survey contained comments from a person about their room, it stated, 'On the odd occasion there has been food debris, stickiness and stains and the bin has not been emptied'. Observations showed that at certain times in the day there were strong, offensive smells within the home. Results of a recent relative quality assurance survey contained comments such as, 'Not always odour free' and 'On the whole it is clean, although my relative's room not always. It gets smelly at times and the bathroom gets neglected'. The Department of Health guidance states 'Achieving and maintaining high standards of cleanliness in care homes is important as it is what residents' and their families' expect and deserve and contributes to ensuring a safe environment for care'. Not maintaining effective infection control could potentially have meant that people were at risk of developing and spreading infections and did not contribute to a homely and pleasant environment for people to live. This is an area of practice in need of improvement.

Risk assessments for the environment, as well as people's healthcare needs were in place and regularly reviewed. For example, each person's care plan had a number of risk assessments which were specific to their needs, such as skin integrity, hydration and nutrition, falls and mobility. The risk assessments identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. One of the risk assessments had identified a risk to a person who liked to go outside to smoke, this person had the capacity to make a lifestyle choice in relation to smoking and risks to the person, as well as others, in relation to inhaling second-hand smoke, had been considered. For example, staff were advised to ensure that the person was wearing warm clothing when going outside and that windows in the surrounding areas were opened to ensure that the smell of smoke was kept to a minimum. However, observations showed staff had not always followed this guidance, several times throughout the day there was a strong smell of cigarette smoke throughout the ground floor of the building, therefore other people were not sufficiently protected from second-hand smoke. Risks in relation to social isolation and people's emotional needs and well-being were not assessed. Several people had a behavioural monitoring charts in place, staff sometimes recorded information if people demonstrated signs of anxiety or distress. However, there was no guidance in place for staff with regards to how to safely manage and support the person to reduce their anxiety and social isolation. The development and implementation of risk assessments that are specific to people's individual needs are areas of practice in need of improvement.

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

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

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and

they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace. One member of staff told us, "I would always report any concerns and see that they were taken seriously, it's our job to keep everyone, residents' and ourselves' safe at all times". Another member of staff told us, "I would report any concerns to the manager or to the shift leader. I would write the details down and see it was followed up. If not I would ring the Safeguarding number or CQC myself".

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff with the relevant skills and experience to meet their needs. People and relatives' confirmed that staff were competent, well trained and efficient. When asked about the experience and competence of staff, one person told us, "Oh yes, the staff are good at what they do". Another person told us, "The staff are good at their jobs". However, despite these positive comments we found areas of practice that required improvement.

Most people had access to sufficient quantities of food and drink and were provided with choice with regards to what they had to eat and drink. One person told us, "The meals are very good, If I didn't fancy the menu, they would do something else for me". Another person told us, "I'm not always happy with the food. I'm very fussy, If I don't fancy the meal, they have done something else for me". There were jugs of squash and water available for people to help themselves to and staff offered people tea, coffee or glasses of lager or sherry with their meals. People had a positive dining experience. People were happy with the environment and the quality, quantity and choice of food available. Most people chose to eat their meals in the main dining area. This was well presented and created a pleasant environment for people to have their meals. Tables were laid with placemats, napkins and condiments. People were able to sit with their friends and we observed people enjoying conversations with one another. One person was overheard saying "You're missing a trick here, this omelette is lovely". One person was observed collecting a compact disc from their room to play whilst they were having their meal, observations showed this person, as well as others, singing along to the music. People were asked for their feedback about the dining experience and the food choices available during meetings with the management team.

However, people who spent their time in their rooms, required assistance with eating and drinking and who had been assessed as being at risk of malnutrition did not always have access to sufficient fluids. The registered manager had implemented good practice by monitoring people's food and fluid intake to ensure they had access to sufficient amounts to eat and drink. However, food and fluid records showed that these had not been completed effectively and observations further confirmed that people did not always have access to sufficient fluids throughout the day. For example, observations showed one person had two drinks, one of which was a hot drink, left on a table that was placed beside them in the bed. The person was lying flat in the bed and was unable to reach the drinks. These remained in place for almost two hours, meaning that one of the drinks had gone cold, and were simply taken away without the person having anything to drink. Another observation showed one person, who also spent their time in bed, being provided with a drink of milk. The member of staff placed the glass of milk on the person's table, with no communication or interaction and walked away. The person was unaware that a drink had been left on their table for them and was only supported to have a drink when the member of staff was called back to assist. Another member of staff who was observed providing a person with their daily nutritional supplement drink, was overheard saying, "You've still got one here from yesterday that you haven't drunk". Records of people's fluid intake raised concerns regarding some people's access to fluids. Records did not inform staff of the recommended daily intake of fluids for the person, and therefore staff were unable to recognise if people had sufficient quantities to drink. Staff had not always completed the records effectively. For example, records showed that sometimes staff had recorded that tea had been offered but had not stated how much

the person had actually consumed. The amount of fluid people had consumed was not totalled each day or monitored to ensure that people were having sufficient amounts to drink. Records for one person, showed that the person had only consumed 200 millilitres of fluid, within a 24 hour period. People were not effectively supported to have sufficient amounts to drink to ensure their health and well-being was maintained. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. This related to a person who was unable to leave the home on their own due to risks to their safety and well-being. The registered manager fully understood the requirements of this legislation and had acted in accordance with it, therefore ensuring that this person was not deprived of their liberty unlawfully. Staff showed a good awareness of DoLS, one member of staff told us, "We need to be aware of the people in the home who are subject to a DoLS but that does not mean that they cannot make choices in other areas of their lives". However, four people had bed rails in place, three of whom lacked capacity to consent to their use. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. The registered manager had not ensured that less restrictive options had been considered, such as the use of low profile beds or crash mats. Mental capacity assessments should be decision specific and assess a person's ability to understand the information related to the decision being made. The person should be able to retain and weigh up the information and communicate their decision. Records should show how the decision of capacity was reached. A mental capacity assessment for the use of bed rails had not been conducted and therefore neither the person, nor their legal representatives had consented to their use. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a commitment to staff's learning and development. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction and there were plans in place to ensure that new staff worked towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. In addition to this, staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs, as well as to have an awareness of the expectations of their role. One member of staff told us, "When I started work I made sure that I made time to read the care plans and to get to know people well, I can see when I come on shift if there are any changes in their manner".

Staff had completed essential training and updated this regularly. In addition to essential training staff had also completed training that was specific to the needs of the people they cared for. For example, staff had undertaken courses in dementia care. There were links with external organisations to provide additional learning and development for staff, such as the local authority and external training providers. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively.

Some staff held diplomas in health and social care. People were cared for by staff who had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

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

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians, district nurses, speech and language therapists (SALT) and physiotherapists. Staff told us that they knew people well and were able to recognise any changes in their behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us, "The chiropodist has visited". Another person told us, "They organise the chiropodist, who comes every six weeks". A third person told us, "They get the doctor in if you are not well".

Good

Is the service caring?

Our findings

People were cared for by staff that were kind and caring. Observations demonstrated that positive and warm relationships had developed between people and staff. People and relatives' confirmed that staff were kind and caring. One person told us, "The staff are kind and respectful". Results of a recent relatives' quality assurance survey contained the comment, 'I have witnessed on many occasions the caring nature of the staff'. A relative told us, "We as a family are very confident and happy with our relative's care here".

People were cared for by a majority of staff who had worked at the home for a number of years and who knew their needs well. It was apparent that positive relationships had been developed. There were warm and friendly interactions between people and staff and people told us that they liked the staff and were happy. One relative told us, "There is a rapport and communication from staff".

People enjoyed interacting with one another and it was apparent that caring relationships had been developed between people as well as with staff. People were encouraged to maintain relationships with one another as well as with their family and friends. Observations showed people engaging in conversations with one another throughout the day. People told us that they were able to have visitors' to the home and that they were welcomed and our observations confirmed this.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identify, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regards to people's religion and care plan records showed that people were able to maintain their religion if they wanted to.

People were involved in some decisions that affected their lives. Records showed that people and their relatives' had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. Most people and relatives confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. A relative told us "I was party to my relative's care plan". Relatives' were involved in their loved ones care as they were observed talking with staff about the care their relative had received. Regular residents' meetings were held enabling people to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. One person told us, "They do have residents' meetings and they would respond to suggestions". Within a relatives' meeting, relatives' had been asked if they would like to participate in regular relatives' meetings, however had chosen instead to talk with staff and the management team, when they visited the home.

People were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives' when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to

enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's privacy was respected. Information held about people was kept confidential, records were stored in locked cabinets and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People confirmed that they felt that staff respected their privacy and dignity. One person told us, "They knock before coming in". Staff respected people's right to privacy. For example, one person, who was sitting in the communal dining room with other people, was questioning a member of staff about their medicines. The member of staff went to the person and knelt beside them and spoke quietly and sensitively with them, explaining their medicines in a sensitive way. Staff were also observed knocking on people's doors before entering, to maintain people's privacy and dignity.

Independence was encouraged. Observations showed people independently walking around the home and gardens, as well as to the local cafe and choosing how they spent their time. One person was encouraged to be independent when eating their meal, as a plate guard had been purchased so that they were able to continue to eat their meal with minimal assistance from staff. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves and records and observations confirmed this.

Requires Improvement

Is the service responsive?

Our findings

People's health and physical needs were assessed and care was provided to ensure that people's needs were met. One person told us, "For me, I do get the care I need". Another person told us, "They reacted quickly last week to my relative being sick by calling the doctor". However, despite these positive comments, we found areas of practice that required improvement.

Although people felt that there were enough staff to meet their care needs, they told us that staff were often too busy to spend one to one time with them to meet their social and emotional needs. Observations showed that staff were task orientated and busy, however, responded to people in a timely manner to ensure their physical and health needs were met. Staff appeared not to have sufficient time to spend time with people, engaging with them or stopping to have discussions. One person told us, "There are enough of them but they are very busy, sometimes when you ask them something they are a little abrupt but it is just because they're busy". Another person told us, "The staff don't have time to be friendly".

Records of staff meetings showed that the lack of time that staff spent with people had been raised with staff, by the management team, on numerous occasions. One comment, made by the operations manager to staff, stated, 'Staff are becoming too task orientated, there are sometimes six or seven people in the lounge but there is not a staff member sitting with them. Staff should be providing emotional support as well. Staff spending time socialising in the lounge, having a cup of tea is still working'. The records went on to state, 'Only staff can change this. At every meeting this has been raised with staff and they need to be doing more interactive activities with the residents, but it seems staff choose not to'. However, observations of a staff handover meeting demonstrated a very task focused approach. Work, such as ensuring supper trays were given out, were allocated to staff coming on duty and there was very little emphasis on meeting people's social and emotional needs.

Guidance produced by the Alzheimer's Society advises that staff should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. Observations showed that one person was showing signs of apparent anxiety, the person was observed walking around the lounge and showing signs of apparent agitation about the plan for the day and when they were going to have their cup of tea. One member of staff was observed walking past the person and did not stop to ask the person how they were feeling or if there was anything they could do to assist. The person continued to show signs of apparent anxiety and only appeared to calm down when speaking to a member of the inspection team.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. People provided mixed feedback with regards to the activities and entertainment that was provided. Some people told us that they had enjoyed the external entertainers that sometimes visited the home, however, felt that there was not enough for them to do and our observations confirmed this. When asked about the provision of activities, one person told us, "There is not enough to do here". The registered manager had organised some external entertainers and events such as singers and a physiotherapist for

exercise classes, on other occasions staff had provided activities such as bingo and skittles. Observations showed that two people were engaged in a game of bingo in the afternoon, other people were sleeping in their chairs or in their rooms. Records of a resident meeting showed that people had discussed purchasing some chickens, eggs had been purchased to enable people to help raise the chickens and observations showed the chickens in the garden. One person told us "I took some lovely pictures when they were chicks, we raised them from eggs, and I watched them hatch".

However, despite this positive area of practice there was a lack of meaningful activities for people, particularly for those that required assistance, were less independent and who spent time in their rooms. The Alzheimer's Society states that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Observations showed people spending their time sitting in their armchairs watching the television or walking around the home, appearing to look for things to do. People, who spent their time in bed or in their rooms, were at risk of social isolation. Observations showed people spending extended periods of time, alone in their rooms, with minimal interaction from staff, other than to provide personal care or to provide food and drink. One person, who was in their room all day, was often calling out in apparent anxiety. Records showed that this was a behaviour the person frequently demonstrated and staff would sometimes record the person's level of anxiety on a behavioural monitoring record. However, we saw that the person had been distressed and anxious several times during the day. It was not apparent that staff had spent any time with the person reassuring them or occupying their time to divert their apparent anxiety. One person told us, "I don't get visitors', I have no family, I get incredibly lonely, the only criticism I have is the boredom". A relative told us, "There is not enough to occupy them, I feel a bit more one to one time with my relative could be an improvement".

One person, who had a DoLS authorisation in place, had conditions associated with their DoLS. The registered manager had ensured that the condition was met as it had recommended that the person have access to a day service. Observations showed the person talking about their time at the day service and how much they enjoyed this. However, the DoLS condition had also suggested that activities to meet the person's abilities and stimulate their interests be provided. The person was observed throughout the day, spending large amounts of time on their own and appearing not to be engaged in any activities other than watching television or listening to music whilst having their lunch. When the lack of meaningful activities and the risk of social isolation were raised with the registered manager, they acknowledged that this was an area of practice that needed to improve, they explained that this had been raised with staff and that they had tried to recruit volunteers within the community to assist with this, however, had not been successful. They recognised that the provision of activities as well the risk of social isolation were areas of practice in need of improvement.

People told us that they were involved in decisions and were able to talk to staff if they ever had any concerns about their health or care needs. People's physical and health needs were assessed and met. People's needs had been assessed when they first moved into the home and care plans had been devised, these documented the person's needs and abilities in relation to their care needs. Care plans were reviewed on a monthly basis, unless changes occurred before this time, by staff and these were based on observations of people's conditions and changes in their health needs throughout the month. It was unclear, from the records that the registered manager kept, that people or their relatives' had been involved in the review process. One person told us, "I know I have a care plan but I've not had a review". A relative told us, "I've not experienced a review in the last twelve months and I've never been informed of the outcome of an assessment my relative had some time ago, communication from the home is somewhat lacking". Records showed that reviews that had taken place had not always captured changes in people's needs. The registered manager had demonstrated good practice by arranging for one person to be assessed by a

speech and language therapist (SALT), the SALT had provided clear, detailed guidance for staff to following in relation to the support the person required when eating and drinking. Observations showed that staff had implemented these actions, however, the care plan reviews had failed to recognise that the person had been seen by the SALT and that there were changes in relation to the person's needs and support requirements.

Care plans did not always contain any person-specific information about people's lives before they moved into the home, their interests, hobbies or social and emotional needs. Information of this nature can help provide staff with an insight into people's lives before they moved into the home, can help to develop relationships and provide more of an understanding of people's holistic needs. When the lack of person-centred information was raised with the registered manager they explained that this was something that the management team had recognised and they had already developed new care plans, which were yet to be implemented, to ensure that the care planning process was more comprehensive and effective.

People did not receive the care and treatment to meet their assessed needs and which reflected their preferences and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

There was a complaints policy in place. Complaints that had been made had been dealt with appropriately and according to the provider's policy. The registered manager encouraged feedback from people and their relatives. Leaflets for Health watch were displayed, informing people of their right to make comments and complaints about the care they received. Health watch England is the national consumer champion in heath and care. People told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager. One person told us, "No, I've not needed to complain, but I would".

Requires Improvement

Is the service well-led?

Our findings

People and staff were complimentary about the leadership and management of the home. They told us that the management team were approachable and friendly. One member of staff told us, "The manager is very good indeed, any problems you have you can go to her and she will listen". Another member of staff told us, "I have been here for seven years and I love it because it is not institutionalised, the manager is very supportive both personally and professionally". However, when asked what they thought about the management of the home, a relative told us "The manager is very nice and approachable, but I question the management". We found areas of practice that required improvement.

A range of quality assurance audits should take place within a home to ensure that the systems and processes used are effective, this also helps to identify areas of practice that need to improve and drives change. A member of the management team undertook quality assurance processes every month with regards to audits for the medication, care plans and the rotas. However, these were not always effective, nor were the audits documented. The management team explained that the audits that were conducted were visual checks and that these were not recorded. There was a lack of robust quality assurance systems and processes within the home. There were concerns with regards to the lack of effective quality monitoring for the range of systems and processes used within the home. This included the observation and monitoring of staff practice with regards to ensuring people were not socially isolated and had access to stimulation, the auditing of care plans which might have highlighted the lack of information in people's reviews and records and the insufficient monitoring of people's fluid levels which could have resulted in people receiving inconsistent care and a poor quality service.

Records, in relation to people's care and treatment, were not always consistently maintained. For example, in addition to the lack of information in people's food and fluid charts, other records, such as moving and positioning charts, behavioural monitoring charts and catheter care charts had not been consistently maintained. One person's moving and positioning chart showed that the person had only been repositioned once in 24 hours, despite needing to reposition frequently to minimise the risk of developing pressure wounds. Another person's record, for the care of their catheter, stated that the catheter bag needed to be changed every seven days, however, records showed that this had not been changed for 15 days. This raised concerns regarding the care people received as it was hard to establish if people had received the necessary care or if staff had forgotten to accurately record their actions in people's records. This was raised with the registered manager who explained that the importance of completing records had been raised with staff within staff meetings and recognised that this was an area in need of improvement. There was a lack of effective quality monitoring systems as well as a lack of maintenance of records relating to the care and treatment of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It had been recognised that as the home was the only home owned by the providers' that there was a risk that best practice was not gained or shared from other homes. Therefore the provider had recruited an operations manager, who worked on a freelance basis with them and other homes, to ensure that the registered manager and the staff were kept up to date with best practice and changes in legislation and

guidance.

Part of a registered manager's responsibilities under their registration with the Care Quality Commission is to have regard, read and consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered manager's responsibility to notify us of certain events or information. The registered manager had followed correct practice by notifying us of some events that had occurred, however had not notified us of a safeguarding investigation conducted by the local authority. Registered managers' are required to inform CQC of these incidents to enable us to have oversight to help ensure that appropriate actions are being taken and to ensure people's safety. When this was raised with the registered manager they explained that they were unaware that this needed to be raised with the CQC as it had already been discussed with the local authority. It was evident that the registered manager had been transparent and open with regards to other events that had occurred within the home and that on this occasion there was a genuine misunderstanding that had led to the lack of notification in relation to the safeguarding incident. Therefore this is an area of practice in need of improvement.

The management team consisted of the registered manager, an operations manager and a team leader. When the management team were asked about their vision and aims for the home, they told us, "To provide quality care for older people in a homely, safe environment. To ensure staff are skilled and qualified and to have a happy team and happy residents". The home had a relaxed and homely feel and people appeared, in the main, to be generally happy and content. When people were asked what the best thing was about living in the home, they told us, "I think the care is the best thing here" and "The best thing is they let you do what you want, like getting up when I like".

The registered manager explained that there were plans to integrate more with other homes and managers' to keep up to date with current practice and guidance and had plans to attend provider and manager forums with the local authority to enable them to achieve this. There were some links with some external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, external training providers' and healthcare professionals'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) (2) (a) (b) (4) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional

and hydration needs.

The registered person had not ensured that the nutritional and hydration needs of service users was met, they did not ensure that there was adequate support for a service user to eat or drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to ensure compliance with the requirements and had not maintained contemporaneous records in respect of each service user.