Peter Coleman

Seahorses

Inspection report

73 Draycott Road
Chiseldon
Swindon
Wiltshire
SN4 0LT

Tel: 01793740109
Website: www.seahorsescarehome.org.uk

Date of inspection visit:
04 March 2016
23 March 2016

Date of publication:
27 May 2016

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

We carried out this inspection over two days on 4 and 23 March 2016. The first day of the inspection was unannounced. There was a delay until the inspection was completed due to the availability of the registered manager.

The last inspection to the service was on 15 May 2014. Shortfalls in the safety and suitability of the premises and assessing and monitoring the quality of the service were identified. In October 2014, a review was undertaken to assess whether improvements had been made to address the shortfalls. The provider and registered manager provided sufficient information to evidence improvements had been made.

Seahorses is registered to provide accommodation and personal care for up to 20 people. However, due to no longer using bedrooms allocated for double occupancy, 18 people were usually accommodated. During the inspection, there were 17 people living at the home. People were living with various stages of dementia and associated conditions.

A registered manager was employed by 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. The registered manager was available for the majority of the inspection.

Audits to monitor the quality of the service were not effective, as shortfalls were not being identified and addressed. Potential risk was being addressed on a generic basis with control measures impacting on people's welfare or activity. This included locking all internal doors to prevent people entering unsupported and removing call bell chords, in response to minimising harm.

Not all areas of the home were clean. This included less visible areas, such as the underside of the bath hoist and along the beading of over-bed tables and in the groves of the dining room chairs. Infection control guidance was not consistently being followed as toiletries and unnamed topical creams were being stored in bathrooms.

Staff knew people well and were aware of their needs. However, care plans did not demonstrate this knowledge. Information did not state how staff should manage particular behaviours or resistance to care. Some care plans lacked clarity regarding the support people required.

Staff and the registered manager told us they received a range of training to complete their role effectively. However, records were disorganised and did not reflect the training staff had completed. Due to this, it was not clear if staff had received training in core subjects such as safeguarding people and dementia care.

Staffing levels were in the process of being increased as it had been identified, an additional member of staff

during the day would be beneficial. During the inspection, the home was calm and people were not waiting for assistance. Staff had time to sit and talk with people.

People were given their medicines in a person centred manner. However, some shortfalls in the procedures increased the risk of error. People were fully supported to meet their health care needs by regular consultations and intervention from professionals such as GPs and district nurses.

The registered manager was committed to people's wellbeing and ensured staff had the right qualities of care and compassion, to support people effectively. Staff had established a good rapport with individuals and treated people with kindness. Staff spoke to people in a friendly manner and promoted their privacy and dignity.

People were supported by staff who felt valued and were well supported by each other and management. Staff had day-to-day contact with the registered manager and regularly met more formally, to discuss their work.

People had enough to eat and drink. The menu did not offer a choice of main meal although staff and the registered manager confirmed alternatives would be given if required. There were no concerns with people losing weight. Meals were generally cooked "from scratch" and specialist diets could be accommodated.

Systems were in place to enable people, their relatives and staff to give their views about the service. Recent surveys showed full satisfaction in all areas. Relatives were aware of how to make a complaint although did not feel they need to do so.

We found six breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we required the provider to take at the end of this 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 service was not always safe.

Not all areas of the home were clean and good infection control guidance was not consistently followed.

There were not always enough staff to meet people's needs effectively although this was being addressed.

Risks were not always appropriately identified and addressed. Some measures to minimise risk were generic and not individual to each person.

Medicines were administered in a person centred way but relevant guidance was not always followed.

Is the service effective?

Requires Improvement

This service was not always effective.

All doors within the home were locked which restricted people's access. Information did not always show the principles of the Mental Capacity Act were being followed.

Records did not show staff had received the required training to do their jobs effectively.

Staff felt valued and were well supported by each other and the registered manager.

People had enough to eat and drink. Their health care needs were appropriately addressed by a range of health care professionals.

Is the service caring?

Good

This service was caring.

The registered manager was passionate about their role and ensuring all staff had the right qualities to consistently offer care and compassion.

Staff knew people well and had established a good rapport with individuals.

Staff spoke fondly of people and were clear about the ways in which they promoted rights to privacy and dignity.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Whilst staff knew people well, care plans did not clearly demonstrate people's needs and the support they required.

Staff were not consistently responsive to people's needs.

Some people received limited stimulation although activities were arranged according to people's ability and interests.

Systems were in place to manage complaints. The registered manager was keen to quickly address any concerns before they escalated.

Is the service well-led?

Requires Improvement

This service was not always well led.

Regular audits were not undertaken and therefore shortfalls were not being effectively identified and addressed.

Not all systems were effective or being consistently followed. The environment was not fully conducive to people's dementia care needs.

The registered manager had worked at the home for many years. Staff and relatives were positive about the management of the home.

Systems were in place to enable people to give their views about the service.

Seahorses

Detailed findings

Background to this inspection

We carried out this inspection over two days on 4 and 23 March 2016. The first day of the inspection was unannounced. There was a delay until the inspection was completed due to the availability of the registered manager.

The last inspection to the service was on 15 May 2014. Shortfalls in the safety and suitability of the premises and assessing and monitoring the quality of the service were identified. In October 2014, a review was undertaken to assess whether improvements had been made to address the shortfalls. The provider and registered manager provided sufficient information to evidence improvements had been made.

Seahorses is registered to provide accommodation and personal care for up to 20 people. However, due to no longer using bedrooms allocated for double occupancy, 18 people were usually accommodated. During the inspection, there were 17 people living at the home. People were living with various stages of dementia and associated conditions.

A registered manager was employed by 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. The registered manager was available for the majority of the inspection.

Audits to monitor the quality of the service were not effective, as shortfalls were not being identified and addressed. Potential risk was being addressed on a generic basis with control measures impacting on people's welfare or activity. This included locking all internal doors to prevent people entering unsupported and removing call bell chords, in response to minimising harm.

Not all areas of the home were clean. This included less visible areas, such as the underside of the bath hoist and along the beading of over-bed tables and in the groves of the dining room chairs. Infection control guidance was not consistently being followed as toiletries and unnamed topical creams were being stored in bathrooms.

Staff knew people well and were aware of their needs. However, care plans did not demonstrate this knowledge. Information did not state how staff should manage particular behaviours or resistance to care. Some care plans lacked clarity regarding the support people required.

Staff and the registered manager told us they received a range of training to complete their role effectively. However, records were disorganised and did not reflect the training staff had completed. Due to this, it was not clear if staff had received training in core subjects such as safeguarding people and dementia care.

Staffing levels were in the process of being increased as it had been identified, an additional member of staff during the day would be beneficial. During the inspection, the home was calm and people were not waiting for assistance. Staff had time to sit and talk with people.

People were given their medicines in a person centred manner. However, some shortfalls in the procedures increased the risk of error. People were fully supported to meet their health care needs by regular consultations and intervention from professionals such as GPs and district nurses.

The registered manager was committed to people's wellbeing and ensured staff had the right qualities of care and compassion, to support people effectively. Staff had established a good rapport with individuals and treated people with kindness. Staff spoke to people in a friendly manner and promoted their privacy and dignity.

People were supported by staff who felt valued and were well supported by each other and management. Staff had day-to-day contact with the registered manager and regularly met more formally, to discuss their work.

People had enough to eat and drink. The menu did not offer a choice of main meal although staff and the registered manager confirmed alternatives would be given if required. There were no concerns with people losing weight. Meals were generally cooked "from scratch" and specialist diets could be accommodated.

Systems were in place to enable people, their relatives and staff to give their views about the service. Recent surveys showed full satisfaction in all areas. Relatives were aware of how to make a complaint although did not feel they need to do so.

We found six breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we required the provider to take at the end of this report.

Requires Improvement

Is the service safe?

Our findings

Not all areas of the home were clean and good infection control guidance was not being consistently followed. There was some black debris on the inside of window frames and brown debris on the underside of toilet seats and around the rim of the toilet bowl. The provider told us the brown mark on one toilet seat was not dirt but due to cleaning which had eroded the colour of the seat. Another toilet seat was of a soft material and there was brown debris around the seam. Toilet brushes contained brown debris and were standing in water. There was food debris within the arms of the dining room tables and against the beading on over-bed tables. Some of the flooring and tiling in the toilets were split, which did not enable them to be cleaned properly. There was brown staining on the underneath of the bath mat in one bathroom and a commode frame was rusted. The underneath of the bath hoist seat was brown and chipped. There was dust and debris between the washing machine and tumble drier in the laundry room. A range of items were in the bathrooms such as razors, a hairbrush and bottles of shampoo and bath foam. There were two pots of topical creams, without labels, which did not show who the creams belonged to. These items used communally, increased the risk of infection. After the inspection the registered manager told us they had addressed these areas.

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

Not all risks to people's safety had been identified and addressed. The plastic covering on the hoist framework was broken and ragged. This gave the risk of injury. All windows on the first floor had been fitted with restrictors to minimise the risk of people falling from a height. Records showed staff had been informed that they were not to remove the restrictors and were to inform management if any were broken. However, the mechanism involved a chain, fixed with screws from the window to the surround. This did not comply with the Health and Safety Executive's most current guidance on window restrictors. This was because with force, the chains could be broken enabling the windows to be fully opened.

Whilst assessments identified some risks to people, they lacked detail and clarity. This did not ensure the risk was sufficiently managed. For example, when a person was having a bath, risks to their safety were identified as slipping or falling. The control measures were staff supervision. Other risks such as scalding hot water or becoming unwell had not been identified. Many risks were addressed by generic constraints. For example, all bathroom doors were locked and required a key to gain entry. The registered manager told us the risks associated with the bathrooms were too high to leave them unlocked. Measures to minimise potential risks had not been considered. One person, who was being nursed in bed, had their bedroom door shut at all times. A key was needed to access the room but a self-release handle meant the door could be easily opened from inside. With the door shut, the person appeared isolated from others and the day to day activity of the home. The registered manager told us leaving the door open was too much of a risk. They said the person was vulnerable and could be assaulted by those people who walked purposefully around the home. There was no written assessment, which considered or minimised this risk to enable the person to have their door open. Risk assessments were in place in relation to the use of call bells. There was a generic decision, which stated people would be at risk of strangulation so no call bell extensions were available. This

meant people had to use the control panel on the wall. The registered manager told us people would not be able to do this, so staff were aware of people's whereabouts to ensure their safety.

Two staff told us due to people's health care conditions, there were some challenging behaviours. These included some people who "hit out" at staff or "lashed out" at others. Staff said these incidents were not frequent, as they had learnt potential triggers to such behaviours and were able to minimise them or intervene effectively. However, any incidents had been managed "in house" and not reported, as required to the local safeguarding team. Information within people's care plans did not show potential triggers or how staff should manage such incidents.

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

Staff told us they would immediately inform the registered manager if they had a suspicion abuse had taken place. They said the registered manager would then take action. They told us they had undertaken training in relation to keeping people safe and often talked about the topic in staff meetings or individually with the registered manager. Records did not demonstrate staff had received this training although the registered manager confirmed all staff had completed it recently. Staff told us they had not ever seen any practice, which concerned them. One member of staff said "I'm very protective so I'd be really angry if I thought anyone had done something to hurt these people. I'd say straight away, I'd have to".

People looked comfortable and relaxed in the vicinity of staff. Relatives told us they did not have any concerns about their family member's safety. One relative told us "I never worry about X. They look after her very well. She's very happy here". Another relative told us "it's not something I've ever thought about. I certainly don't worry about X being here. She's always very settled and is happy to come back if we've been out".

Some people were prescribed medicines to be taken "as required". There was no information available to staff to ensure these medicines were administered, as prescribed or to ensure maximum effectiveness. Five medicine administration records did not contain a photograph of the person. This increased the risk of medicines being given to the wrong person. Information stated staff gave homely remedies to people for a period of 48 hours, for conditions such as a headache or constipation, without consultation with a GP. This practice had not been authorised individually for each person, by a medical professional. This presented a risk the homely remedies could counter-interact with the person's prescribed medicines, causing ill effect. During the inspection, staff checked the delivery of people's medicines for the following week. Despite having a specific room for medicines, they did this in the dining room. The medicines were not left unattended but distractions from people in the vicinity increased the risk of error.

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

Staff told us only those staff trained to do so administered people's medicines. They said they received regular training to ensure their skills were satisfactorily maintained. Records did not demonstrate this. During the inspection, one member of staff appropriately dispensed the medicines from a monitored dosage system. They gave the person their medicines in a person centred way, whilst another member of staff observed the interaction. Both staff signed the medicine administration record (MAR) to show the medicines had been given or declined. Staff had consistently signed the record, which gave an accurate portrayal of the administration of medicines for monitoring purposes. The registered manager told us they did not like people being prescribed medicines to manage behaviours or agitation unless it was a last resort.

They said this was because many such medicines caused side effects such as falls. They said they would much prefer giving people time and reassurance if possible.

During the inspection, the home was calm and people were not waiting for assistance. In the morning there were four staff on duty. This reduced to three in the afternoon and there were two waking night staff. Of these four staff in the morning, two supported people with their personal care. One member of staff undertook cleaning responsibilities and another worked in the kitchen and cooked lunch. Staff told us staffing levels were satisfactory although they felt additional staff would enhance the service people received. One member of staff told us more staff would be beneficial, especially when people became unsettled or anxious. Another member of staff said additional staff would help, particularly in the morning, when assisting people to get up and dressed. One person's care plan stated staff took it in turns to sit with them. With there being only two care staff to assist people, maintaining this support was challenging. Staff told us they had discussed staffing levels with the registered manager and felt they had been listened to. The registered manager told us adequate staffing levels were always maintained but an additional member of staff would be beneficial. As a result of this, the registered manager said an additional member of care staff was being deployed each day, starting from 1 April 2016.

The registered manager told us the provider lived on the premises so was available in the event of an emergency. In addition, they said they and the majority of the staff team lived locally so would come into the home, if required at short notice. They told us the staff team was extremely stable, with no new staff having commenced employment at the home for many years. The registered manager told us due to this, no agency staff were used. Existing staff covered any shifts at times of staff sickness or annual leave. The registered manager told us staffing levels were determined according to the number of people in the home and their needs. They told us whilst ensuring the home was properly covered and safe, they ensured people's needs were always manageable. This included bearing in mind the dependency of people, when admitting a new person to the service.

As no new staff had been appointed, we did not look at the information, which showed the home's recruitment procedures. The registered manager told us about the procedure they would follow when recruiting staff. This ensured any appointed staff member would be suitable for their role and for working with vulnerable people. There was an up to date policy, which described the recruitment procedure, as described by the registered manager.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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).

There were records about consent in people's care plans. However, information did not consistently show those people involved in decision making. There was a "yale" type lock fitted to all bathroom and bedroom doors. This meant a key was required to gain access. The registered manager told us if people were able, they could have a key to their room although these often got lost. They said people generally asked staff to open their room for them, when required. The registered manager told us this restriction was necessary to ensure people's safety and that of their property. Restrictions on people's movement and the implications of this had not been considered. There was a restraint policy, which gave a description of restraint as "bedroom doors locked and service users are unable to access their rooms". The policy stated restraint was not used in the home. However, as all doors were locked and people had restricted entry, this was not entirely accurate.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had completed a three day training course related to the MCA and DoLS. They said this had been useful in developing their knowledge of the topic. They said a DoLS application had been submitted to the local authority for each person who used the service. They said this was because people were unable to leave the home unsupported, as they would not be safe to do so. The registered manager told us whilst all applications had been submitted, not all had been processed. They said they aimed to enable people to make decisions as far as possible. This included choosing what time they got up and retired to bed at night. The registered manager told us the use of covert medicines was discouraged unless as a last resort. Covert medicine is when a person is given their medicines, disguised in food or drink, without their consent. The registered manager told us in such cases, a multi-disciplinary meeting would be held to consider the person's best interests, in accordance with the MCA.

People told us they liked the food. One person said "yes, it keeps me going. I'm never hungry". Another person told us "it's very nice but we do get a lot of carrots" They told us the Sunday roast was their favourite meal. Another person told us their meal was "was worth waiting for". Relatives told us they had no concerns about the food provided although were not always present at meal times. One relative told us their family member enjoyed the food. They said "X is always eating". Another relative told us their family member had

put on weight, so felt this was indicative of good food.

Staff told us people were offered a choice of meals according to their preferences. They said they knew people well, so through experience, knew individual likes and dislikes. There was a weekly menu, which the cook had developed. The menu showed a choice of cereals and toast with preserves for breakfast. At lunch time, there was a main meal and a dessert. The meal was traditional in nature but there was no alternative. The registered manager and staff told us whilst a choice was not stated, alternatives were always given if people "fancied something different". They said they knew if a person disliked a particular food, so this would not be offered. On the first day of our inspection, people were served fish, chips and tinned tomatoes. Staff told us the chips were not frozen but cooked "from scratch". One person had sponge and custard for their desert. They said "I love it. It's lovely" as they were eating it. On the second day of the inspection, one person did not eat their meal. They told staff they did not like it. Staff asked if they wanted a dessert but they said "no". In response to this, the member of staff asked "what would you like? What can we get you?" The registered manager told us people were not losing weight although one person was eating small amounts and at risk of malnutrition. The registered manager told us a referral to a dietician had been made. They said cream was added to foods such as mashed potato to give additional calories. Some people enjoyed jelly made from fortified drinks. The registered manager told us they tried to be creative, to ensure people received sufficient nutrition. They said as much food as possible was cooked "from scratch" using fresh produce and there were regular deliveries of food. There was a range of fresh vegetables in the kitchen. A delivery of food had been received on both days of our inspection. Staff told us specialised diets, related to people's health or cultural needs could be accommodated but were not required at this time.

The registered manager told us all staff had received the training they required to do their job effectively. This included topics such as keeping people safe, food hygiene, infection control and moving people safely. Staff confirmed this. One member of staff told us "they make sure we're kept up to date with everything we need to know. We do a lot of training here". Another member of staff told us they had achieved a qualification, which they had never expected to do. They said their confidence had improved greatly, as a result of the help they had been given to complete the course. Another member of staff told us they had undertaken food hygiene training so they could work in the kitchen but had also done all other training, to be able to support people effectively. Whilst the registered manager and staff told us training was regularly arranged, this was not evidenced within documentation. There was a training file, which contained an abundance of information but it was not in any order. Many certificates showed training, which was out of date. The information did not evidence staff had undertaken the training they required. The registered manager told us they were aware the training file was "in a pickle" and said this would be addressed after the inspection. They told us as they had a small staff team, they could store information about training in their head. They said they knew exactly when staff needed to update their training but this was not recorded. The registered manager told us they had searched the internet for a format, such as a training matrix to record this information but had been unsuccessful in doing so.

The registered manager told us it was important to them, to support their staff. They said they met with staff on a day to day informal basis to ensure there were no concerns and "all was well". Staff confirmed this. They said they felt extremely supported by the registered manager and the provider. One member of staff told us they were able to discuss any issues whether they were work related or about their personal life. They said any difficulties were always sorted out, in a positive manner. Another member of staff told us they always felt valued. They said the registered manager was very good at suggesting ways to do things, without making staff feel they had been doing things wrong. They said the registered manager always thanked them for their work and told them they were doing a good job. Staff told us they worked well as a team and also supported each other well. They said they "looked out for each other" and would help out where ever they could.

In addition to informal support, staff told us they regularly met with the registered manager to discuss their work. They said they discussed particular issues of people's care and the best way to manage them. Staff said they also talked about topics such as training. Records showed these meetings took place every two to three months. Staff told us this frequency was sufficient, as they had regular day to day contact with the registered manager. They said they always raised issues as they arose and did not feel they needed to wait for their formal meeting. The registered manager told us they encouraged staff to do this. They said staff knew they were not to leave the building unhappy or stressed about a situation. They were always encouraged to "air their views" and resolve issues without escalation. Records of the meetings held with staff were signed by the registered manager and the member of staff. This showed a "two way" process with both parties contributing. However, the information did not always show specific requests had been actioned. This included one record where the member of staff had asked for more training. There was no action plan in place, to show what training was required and if it had been arranged.

People were supported to maintain good health and had access to appropriate healthcare services. On the first day of the inspection, one person was unsettled. The registered manager explained the reasons for this and said they had requested a visit from the district nursing service. The district nurse visited and arranged for the person to go to hospital for treatment. The registered manager accompanied the person, to provide a familiar face and to minimise further stress or disorientation. They said a GP visited people on a routinely, fortnightly basis and more regularly if requested to do so. Staff confirmed this. They said they only needed to ring the surgery and the GP or district nurse would visit. They said people received services such as chiropody, as required. The registered manager told us the community matron authorised the storage of "rescue medicines" such as some antibiotics. This meant if a person had symptoms of a urinary tract infection, which was confirmed through testing, the community matron could initiate a course of antibiotics. This enabled effective treatment quickly without the need to wait for a GP to visit. The registered manager told us this process had also been beneficial in minimising admissions to hospital.

The registered manager told us the home received good support from health care services although sometimes had to "wait their turn", due to local demand. They said this was particularly apparent if specialised services such as physiotherapy or speech and language therapy were required. The registered manager said they had developed good relationships with the local mental health team and specialised personnel such as psychiatrists. Relatives told us their family member was well supported in terms of their health care. One relative said their family member's health had improved since being at the home and they had experienced less falls. They were confident any health issue would be competently addressed. Relatives told us they were kept informed of their family member's health. This included if their family member was unwell or had seen the doctor.

Good

Is the service caring?

Our findings

The registered manager told us the people who used the service were their first priority. They said they were committed to people's wellbeing and wanted the home to be comfortable, homely and relaxed. The registered manager told us "you have to be a special type of person to work here. You have to be kind, caring and compassionate otherwise the work is not for you". They said these factors were essential attributes, needed for all staff. The registered manager said they would not employ staff who "just wanted a job". They felt it was specialised work, which required special qualities including a very caring manner and an overall concern about people's welfare. The registered manager said staff needed to go the "extra mile" due to the health conditions of the people they supported. The registered manager told us they were lucky, as all of their staff had these attributes and took pride in their work.

The registered manager told us people's family were an important part of the home. They said they could visit at any time and were made to feel welcome by staff offering refreshments. The registered manager told us relatives were able to eat with their family member if they wanted to. They told us one person did not appear to have any immediate family. Due to the negative impact on the person's life, the registered manager told us they tried, with the support of the local authority to trace distant relatives. This was successful and the person now benefitted from receiving visitors, at varying frequencies. The registered manager told us people's cultural requirements were important and support was given to promote these. They said it was often difficult, particularly for relatives, when a person's dementia advanced and their values no longer appeared so important to them. They gave an example of one person who no longer appeared to want to practice their faith. The registered manager told us "we can't force people, we can only guide them. If they don't want to do something, that's their choice".

Staff spoke fondly about people. They said they had known people for many years and in some cases, had seen people's mental health deteriorate over time. Staff commented about the negative impact dementia often had on the person and their family. One member of staff told us "I think it's one of the worse conditions you can get. It must be horrible". Staff told us how they enjoyed their work with particular attention to providing emotional support and minimising any distress people experienced. One member of staff said making people smile was important to them. They told us they were aware terms of endearment should not be used although felt some people benefitted from this. The staff member told us "if I didn't call X by their Christian name or use the word "love", they would think something was wrong". Staff told us they had developed a good rapport with people and therefore were able to minimise certain anxieties. They gave an example of how they distracted one person when they became agitated after their relative had left. This was demonstrated during the inspection when staff asked the person to help them in another part of the home, whilst their visitor left. The distraction enabled the person to remain relaxed and content with their environment.

Staff spoke to people in a friendly and respectful manner. They often said "you're welcome" or "it's a pleasure" when being thanked by people. Staff responded appropriately to situations, which compromised a person's dignity. This included supporting a person quickly when they started removing their clothing due to agitation. Another member of staff asked if they could adjust a person's clothing, as it had become

dishevelled. One person looked anxious and was not aware of where they were. Staff gave reassurance and offered their arm for support. The person smiled and responded to the staff member, as they made their way back to the lounge. The registered manager knelt down on the floor whilst talking to a person. They stroked the person's arm, as they were trying to find the cause of their anxiety. One member of staff gave a person assistance to drink. They did this in a dignified, sensitive manner. However, one person's dignity was not maintained. The member of staff asked the person if they would make their way to the bathroom so their continence aid could be changed. Whilst it was acknowledged the person may have had poor hearing so needed staff to speak clearly, the request would have been heard by those people around.

Staff were confident when telling us how they maintained people's rights to privacy and dignity. They said they always ensured personal care was delivered in private, with doors closed and curtains drawn. One member of staff told us they always tried to ensure they informed people what was happening, especially when delivering personal care. They said they promoted independence by encouraging people to do as much as possible for themselves. They gave an example of giving a person a flannel and directing them to a part of their body, which needed to be washed. The staff member told us once they had started to do this, people were usually able to continue due to the routine they previously had. Another member of staff told us they ensured the person was warm, well covered and comfortable. They said it was important to be gentle and see each person as a person with dementia rather than seeing the dementia first. The member of staff said they tried to find out as much as possible about the person and their earlier life. This enabled greater understanding of the person's traits and behaviours, as well as providing topics for conversation. The registered manager told us this was important in relation to one person who did not sleep well at night. They said the person used to work nights so was used to sleeping in the day. Staff told us they always addressed people as they wanted to be known. This included using a "nick" name of a person, as they had used it instead of their Christion name, for many years.

Relatives were positive about the staff. They told us they were "very good", "superb", "really caring", "friendly" and "very patient". One relative told us "it's the staff and their care that makes the home". Relatives told us their family member was supported appropriately and their rights to privacy and dignity were maintained. One relative gave us an example of how staff had managed a particular behaviour well. They said the staff's interaction had promoted the family member's dignity and in turn had minimised the impact, on those in close proximity. They told us staff would ensure their family member's clothing was changed if it was soiled, after a meal. The relative told us their family member always looked clean and well presented. They said this indicated a good standard of care with clear consideration given to the importance of personal identity and appearance. Another relative made similar comments. They said their family member was always encouraged to follow their preferred routines. This included staying in bed for a "lie in" if they wanted one. They said their family member liked to wear co-ordinated clothing and staff supported them to do this. Relatives told us staff were concerned about their wellbeing, as well as their family member. One relative told us this was particularly apparent during the transition period, when their family member moved into the home.

Requires Improvement

Is the service responsive?

Our findings

Whilst staff appeared to know people well, this was not evidenced within care documentation. Care plans were limited in their detail and did not fully show the support each individual required. Staff told us one person could become agitated if they were spoken to in a loud voice. This and other measures to minimise the person's agitation were not stated in their care plan. Information did not inform staff what they should do, when the person was resistive to care. Another person had a syringe in their room, which staff used to help them to drink. This was not stated in the person's care plan and there were no specific details about how to support the person to eat and drink. Another person was being assisted to eat their lunch time meal. They had an "episode" where they did not respond to anything around them. The member of staff reassured the person, stroked their arm and said "they often do this. They'll be ok in a minute". The person then responded and continued eating. These episodes and how they were to be managed were not documented in the person's care plan. Another care plan stated the person needed "total personal care at the moment". There was no detail to confirm what this meant. Information stated the person used continence aids but there was no information about the assistance to manage these or to use the bathroom. It was stated on a "good day" the person required prompting, but on "bad days" they required full staff assistance. The definition of "good" and "bad" days was not stated. An assessment identified the person was not at risk of falls. However, this was not accurate as the daily records showed the person had experienced a number of recent falls.

Other care plans lacked detail. This included one plan stating "X needs guidance with her personal care. Self able". It was not clear what this meant in practice. Later in the plan, the person's deterioration was identified and it was stated they needed two staff to help with washing and dressing. The information did not identify why two staff were required and what they needed to do. The person's continence plan had not been updated to reflect the changes in need. Within the person's daily records, it was recorded there was a bruise on the person's arm. The entry did not give further detail such as the size and colour of the bruise.

Staff were not always responsive to people's needs. One person repeatedly called out saying they wanted to leave the home. Staff did not always respond to the person when they did this. The person was not occupied in any activity and therefore not distracted from such behaviour. On one occasion, another person who used the service shouted "shut up" in response. The registered manager told us calling out was a trait of the person, which they did whether they were with people or not. They said staff had not been able to minimise the calling out even when spending time with the person. However, once staff sat down with the person, they appeared more content and relaxed. At one point, they were looking at the member of staff saying "I do love you. You're very special to me". When the staff member got up to leave, the person told them "don't go. Don't leave me". The person clearly enjoyed the staff member's company and benefitted from the contact given. The staff member told them they had to go, as they had other people to look after.

At lunch time, staff gave pleasantries such as "enjoy your dinner" but they did not explain the contents of the meal to people. This would have ensured people knew what they were eating before they started. Staff asked people if they wanted a drink and then proceeded to pour orange squash from a jug. People were not offered a choice. Throughout the inspection, people were encouraged to remain seated. Staff guided people

back to the lounge or asked people "sit down here X" or "can you sit down please". One person walked into the kitchen but was told "not in here X, you're not allowed in the kitchen are you?" The person was led back to the lounge where they were encouraged to sit in an armchair and relax. This did not promote independence or assist people with what they were looking for.

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

During the SOFI observation, not all people received interaction and stimulation. One person slept for the majority of the morning. Staff noted they had leant over the arm of their chair, in an uncomfortable manner. In response, they placed a cushion by the person's side to make them more comfortable. Other than this, the person was not involved in any other interaction. Another person also slept at varying intervals. They opened their eyes and looked ahead, without engaging in their surroundings. Staff did not interact with the person whilst they were awake. Another person received positive interventions from staff. The person had suffered an un-witnessed injury causing skin tears to their legs. Staff regularly asked the person if they were alright and encouraged them to elevate their legs, to minimise any bleeding. They offered the person a drink and asked if they needed anything, at regular intervals.

On the first day of the inspection, staff spent time talking to some people. This included talking to one person about their previous occupation of owning a fish and chip shop. They asked the person if the home's fish and chips were as good as theirs and the person laughed. Another member of staff spent time with a person, looking at a newspaper. On the second day of the inspection, people were involved in a musical session. This included singing and playing percussion instruments, such as tambourines. The majority of people appeared to enjoy the session. The registered manager told us people were often limited in the activities they could participate in. They said the most popular activities were found to be musical and some people liked "adult" colouring books. One member of staff told us they always spent time talking to people about their interests, family members or pets they used to have. They said people often liked to make Birthday or Christmas cards for their family members. The registered manager told us, as people liked musical activities, they regularly arranged external entertainers to undertake shows or "sing-alongs". These sessions were usually undertaken with refreshments, to make a "party feel". They told us they encouraged staff to view all interactions, as activities. This included being assisted to have a bath or getting dressed in the morning. The registered manager told us staff were aware they needed to make each interaction special and meaningful, with added purpose, than purely achieving the task.

One relative told us staff got to know their family member well and found out what was important to them. This included the person's previous occupation and interests. The relative told us staff arranged social activity, in accordance with these areas, so their family member could participate. They said "it's like home from home. Staff sing, dance and have a laugh. They tune into people's sense of humour". Another relative told us "I can't think of anything that needs to be improved although I suppose, if there's anything, I'd like X to be involved in a bit more activity. Saying that she probably wouldn't want it so there's nothing really they could do better. X is very happy "people watching" and there's lots of that".

Whilst records were limited in their detail, staff were aware of people's needs and the support they required. One member of staff told us how they used body language and facial expressions to determine what people wanted. Another member of staff told us how they diffused situations, by using a calm and reassuring manner. They said they talked to people about what was important to them. To encourage people to make decisions, staff told us they used short, simple questions, which people could understand. One staff member told us "it's no good giving a long list of things people can choose from. It's much better to give two options or show people what you're offering". Another member of staff told us how they tried to minimise certain

behaviours by the way they interacted with the person. They gave an example of one person who often touched staff inappropriately. The member of staff told us "I'm very conscious of how and where I stand so touching me would not be possible. It makes it easier and stops it from happening, which is better for the person". The registered manager told us they had discussed aspects of people's dementia care with a specialist consultant. They said they had been told it was "pointless bringing people living with dementia back to the future". Due to this, they said they always ensured staff were sympathetic to the person and put themselves "in the person's shoes". However, one approach used by a member of staff was not appropriate. This was because a person asked them, "where's my mum and dad?" The staff member replied "they've gone shopping". The person answered "no they haven't. They're dead". The person was not upset by this but the staff member's response was not helpful.

Staff told us some people were able to verbally tell them, if they were unhappy with the care they received. They said other people would not be able to verbalise this information. Staff told us if they suspected there was a problem, they would use body language and the person's overall demeanour, to find out more. One member of staff told us "it's trial and error sometimes to find out what's wrong. Often it's ruling out things, before you find the problem". Relatives told us they had no cause to complain but would speak to the registered manager or provider, if there was a problem. They were confident any issues would be satisfactorily addressed in a timely manner. The registered manager told us they aimed to address any concerns at an early stage, to minimise any escalation. They said any concern was taken seriously. The registered manager said they would offer people or their relatives a meeting to discuss their concerns and would try to resolve things, as quickly as possible. Information stated every effort was made for the issue of concern, not to happen again. The registered manager told us they had not received any recent formal complaints. Records showed a letter of apology had been sent in relation to one concern. The information explained why the incident had happened and gave the person further opportunity to discuss issues, if required. A written copy of the complaints procedure was displayed on the notice board in the entrance hall. The notice board was a sealed unit, minimising the risk of documents being displaced.

Requires Improvement

Is the service well-led?

Our findings

Information showed there were a range of audits to assess the service. However, the audits were in line with the National Minimum Standards, which were no longer in operation. The audits generally related to systems, such as structures or policies being in place. They were not effective in identifying shortfalls, as identified during this inspection. The majority of the audits were undertaken on a six monthly or annual basis. This frequency was insufficient in monitoring the quality of the service effectively. For example, there was a cleanliness and infection control audit which was undertaken in January 2016, with a review date of July 2016. The infrequency of audits had not identified the lack of cleanliness within the home.

All policies and procedures had been reviewed. However, not all management systems were effective or being consistently followed. For example, the cleaning schedules informed staff of the tasks to complete in people's bedrooms. They did not cover communal areas or less visible areas such as the grooves on dining room chairs. The infection control policy stated staff should dispose of their protective clothing safely, in yellow coloured clinical waste bins. However, disposable gloves and empty red plastic bags, which were used to carry soiled linen, had been placed in a waste paper bin, without a protective lining. There was a file which contained information about the safe storage and use of substances hazardous to health. The majority of the information was not in date and had not been regularly reviewed. The training file lacked organisation and did not demonstrate the training staff had completed.

The environment did not reflect people's dementia care needs. People did not have their names or a picture of something important to them, on their bedroom door. There was no signage to direct people to specific rooms such as the lounge or dining room. This did not enable people to easily orientate themselves around the home. There was no use of colour in the corridors or any stimulatory objects to engage people in their surroundings. The registered manager told us these factors had been tried in the past but had been unsuccessful. They said this was because they could not be maintained effectively, as people often took or moved things from the walls. Not all systems were in an easy to understand format. This included the complaints procedure, which was written in a popular font without pictures or creative measures, to enhance involvement.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us an external company was used to monitor health and safety. They said this involved checking water temperatures and the risks of legionella. There was a file containing comprehensive information about the water systems. At the end of the file, there was an action plan showing recommended work. The information did not state whether this work had been addressed. The registered manager told us all work had been completed and they sent us confirmation of this, after the inspection. Records showed small portable appliances had been checked to ensure they were safe to use. An external company had completed an assessment to minimise the risks of fire. All fire safety equipment had been checked at regular intervals to ensure it was in good working order. An external company had serviced equipment such as the bath hoist and the passenger lift. Information showed there were some aspects of the passenger lift, which

had been recommended for replacement. Records did not show this had been undertaken. As with the water systems, the registered manager told us all recommendations had been undertaken, with no outstanding works. Staff told us the kitchen had recently been inspected and no recommendations were made. They said five stars were awarded, which was the highest available. The registered manager told us work tops in the kitchen had been replaced with a stainless steel design, to achieve this.

One relative told us they felt some areas of the home could do with some redecoration. However, whilst saying this would be beneficial, they did not feel it was paramount, as the standard of care was very good. The registered manager told us there was not a formal refurbishment plan of the home, as such. They said work was undertaken, as required and when funds allowed. They told us some bathroom and bedroom flooring was in the process of being replaced. Consideration was also being given to replacing the lounge carpet.

The registered manager had worked at the home for many years. They said they worked closely with the provider and were able to gain advice, when required. The registered manager told us the provider was excellent. They said they had a positive attitude and were 100% committed to the home and people who used the service. The registered manager told us they enjoyed their work and were passionate about caring for people with dementia. They said they worked hard to ensure a relaxed and comfortable environment for people. This involved carefully assessing people to ensure the home could meet their needs effectively. They said on admission, much of the work was "trial and error" until staff became familiar with people's needs. They said people needed to be given time to settle and be familiar with their surroundings. The registered manager told us it was important to keep the balance of people's needs. This was so the atmosphere of the home could be maintained and staff were not overloaded.

The registered manager told us they regularly worked with people and staff to ensure good role modelling. They said this also enabled them to be aware of people's needs and the challenges staff were facing. Staff told us the registered manager was very "hands on". They said they were very approachable and were well thought of. One member of staff told us the registered manager and provider "had hearts, which were in the home and they did what was best for people". Another member of staff said "X [the registered manager], will help on the floor. They're always around. I love it here. It's very homely". The staff member told us the registered manager and provider always provided what was needed in the home. Another member of staff told us "the manager is very good at balancing staffs' moans. They do a good job of keeping everyone happy". Relatives were equally positive about the management of the home. They told us the registered manager and provider were very approachable and promoted a homely atmosphere. One relative told us the registered manager and the provider were "always in the home" and could be spoken to at any time, if they had a problem.

Records showed people, their relatives and staff were encouraged to give their views about the service. "Resident and relative" meetings were held. This enabled information to be shared and new ideas to be suggested. One meeting showed people had been given carpet samples and encouraged to say which they preferred. This was in preparation for the replacement of the lounge carpet. Relatives had not routinely attended the meetings although had been invited to do so. There were a number of surveys, which people had completed with the help of their relatives. This gave feedback about the service people received. The results of the surveys showed satisfaction throughout. However, the information received was not coordinated and readily displayed for people to view.

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 11 HSCA RA Regulations 2014 Need for consent Records did not demonstrate the MCA had been consistently followed in relation to consent to care and treatment. Some practices such as locking people's bedroom doors did not enable freedom of movement. The decision for this restriction was not clearly evidenced. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Less visible areas of the home were not clean. Infection control guidance was not always being followed12(2)(h).Risks to people's safety were not consistently identified and appropriately addressed. 12(2)(a).Care plans did not clearly demonstrate people's needs or the support they required 12(1). Medicines were not always safely managed as there were no protocols for "as required" medicines and homely remedies were not person specific 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The auditing system to monitor the quality of the service was not effective in identifying and addressing shortfalls. Regulation 17(2)(a)