Ridgemede Care Limited

Ridgemede Care

Inspection report

Bishops Waltham
Southampton
Hampshire
SO32 1DX

Tel: 01489892511

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 October 2016 and was unannounced. Ridgemede Care is a care home that provides accommodation for up to 36 people, including people living with dementia care needs. There were 25 people living at the home when we visited. The home is based on two floors with an interconnecting passenger lift. All bedrooms have en-suite facilities. In addition, bathrooms are provided on both floors, together with a range of communal rooms for people's use.

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

At our previous inspection on 4 & 5 August 2015, we identified four breaches of regulations. Medicines were not always managed safely; risks to people were not always assessed and mitigated; staff did not follow guidance designed to protect people's rights; information about the employment histories of staff was not always available; and quality assurance processes were not always effective. The provider sent us an action plan detailing the steps they would take to become compliant with the regulations. At this inspection we found action had been taken, but further improvement was required.

Providers are required to conspicuously display their CQC performance ratings on their website and within the home. The rating from the previous CQC inspection was not displayed on their website. Within the home, the rating was displayed on the office wall, but was not easy for people to see.

A new policy had been introduced which required staff to act in an open way when people were harmed. Whilst staff had been open with family members after a person fell, they had not followed this up with a written explanation as required.

There were appropriate arrangements in place for managing medicines. However, the quantity of medicines in stock was not carried forward from month to month, so the provider was not able to check that people had received their medicines as prescribed. The registered manager was still developing a system to regularly check the competence of staff to administer medicines.

Regular checks were conducted to make sure the building was safe for people, although these had not identified that some first floor windows did not have restrictors fitted to prevent people from falling out.

Improvements had been made to the way staff assessed people's ability to give informed consent. Staff sought verbal consent before providing care and support, and knew how to protect people's freedom. However, further work was needed to ensure that action taken to protect people's rights was fully documented.

A quality assurance process had been developed. This had identified and addressed some areas that needed improvement. However, it needed further time to become embedded in practice to ensure it was effective.

People were protected from harm in a way that supported them and respected their independence. Staff knew how to keep people safe and how to identify, prevent and report abuse. They engaged appropriately with the local safeguarding authority.

There were enough staff to meet people's needs and recruitment processes helped ensure only suitable staff were employed.

People's needs were met by staff who were skilled and suitably trained. New staff completed a comprehensive induction programme and all staff were suitably supported in their roles by the management team

People praised the quality of the food. Their dietary needs were met and staff provided people with appropriate support to help ensure they ate and drank enough. Staff monitored people's weight and took action if they started to lose unplanned weight. People could access healthcare services and were referred to doctors and specialist nurses when needed.

People were cared for with kindness and compassion. Staff interacted with them in a positive way. They spoke about people warmly and demonstrated a detailed knowledge of them as individuals. They were skilled at communicating with people living with dementia.

Staff protected people's privacy and encouraged them to remain as independent as possible. They involved people in the care planning process and kept family members up to date with any changes to their relative's needs.

People received personalised care and support that met their needs. Care plans had been developed which provided staff with detailed information about they should meet people needs. People were encouraged to make choices about every aspect of their daily lives.

People praised the range of activities they could access. These had been tailored to their individual interests and included trips to local attractions. Positive links had been built with the community. For example, the home hosted 'mother and toddler' groups and children from local schools visited to interact with people, which people enjoyed.

People felt the home was run well. There was a clear management structure. Staff understood their roles and worked well as a team. They were happy in their work and felt supported by managers. The provider promoted values of kindness and dignity, which staff worked to.

There was an appropriate complaints procedure in place and people knew how to make a complaint. The provider sought and acted on feedback from people. They had invested in the service and had plans to develop it further.

We identified a breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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 service was not always safe.

Medicines were not always managed safely. The provider was not able to account for all medicines in stock in order to check that people's medicines were being given as prescribed.

Window restrictors were not in place for all first floor windows, which posed a risk to people. However, other environmental and individual risks to people were managed effectively. There were suitable plans in place to deal with foreseeable emergencies.

People felt safe at the home and staff knew how to identify, prevent and report abuse. There were enough staff to meet people's needs and the process used to recruit staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights. However, they asked people for their consent before providing care and support.

People's needs were met by staff who were suitably trained. Staff were supported appropriately in their role and could gain vocational qualifications.

People's dietary needs were met and they received appropriate support to eat and drink when needed. People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They protected people's privacy and dignity at all times.

People were encouraged to remain as independent as possible and were involved in planning the care and support they

received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People had access to a wide range of meaningful activities. People were supported and encouraged to make choices about every aspect of their lives.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance process had been improved but needed time to become effective. The provider's previous CQC rating was not displayed clearly on their website or in the home. Staff acted in an open way when incidents occurred, but did not provide information in writing to family members.

There was a clear management structure in place. Staff were positive about the management and felt supported in their work.

The provider's values of kindness and dignity were communicated to, and followed by, staff. Positive links had been made with the community which benefitted people.

Ridgemede Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was also carried out to check whether improvements had been made from the August 2015 inspection.

This inspection took place on 20 October 2016 and was unannounced. It was conducted by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people living at the home, two family members and a visiting community nurse. We also spoke with the operations manager, the registered manager, the assistant manager, five care staff, the activities coordinator and the cook. We looked at care plans and associated records for four people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records. Following the inspection, we received feedback from a social care practitioner from the local safeguarding team and a nurse practitioner from the local doctors' surgery.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in August 2015, we identified a breach of regulations as risks to people were not always managed appropriately and medicines were not always managed safely. The provider wrote to us detailing how they would become compliant with the regulations. At this inspection we found action had been taken but some further improvement was needed.

There were appropriate arrangements in place for the ordering, storing and disposing of medicines. Staff were suitably trained to administer medicines and the registered manager assessed their competence through discussions and observing their practice as part of the initial training. Two to three times a year, the registered manager also held 'medicines meetings' with staff who were authorised to administer medicines. These were used to refresh staff knowledge and highlight particular aspects of the process. The registered manager told us they were also developing a process to re-check the competence of staff to administer medicines on an annual basis.

There was a process in place to help ensure that sufficient medicines were in stock for people and repeat prescriptions were submitted before people ran out of their medicines. However, medicine recording processes were not robust. Medication Administration Records (MAR) were used to provide a record of which medicines were prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicines. The MAR charts were renewed each month when the new stock of medicines was received. However, the quantity of any remaining boxed medicines left in stock was not carried forward and added to the new MAR chart. When we checked the quantity of tablets in stock with the number shown on the MAR chart as received and given, the numbers did not tally. This meant the provider was not able confirm that people had received their medicines as prescribed. We discussed this with the registered manager, who agreed to introduce a system for carrying forward stock from one month to the next.

Suitable checks were made to help ensure the building was safe for people. However, these had not included checks of the safety of first floor windows. Whilst most had restrictors in place, to prevent people falling or climbing through them, we identified four windows did not have restrictors fitted. These posed a risk to people, particularly those living with dementia, who had access to these windows and might not appreciate the risks. We brought this to the attention of the registered manager, who agreed to address the concern as a priority.

Other aspects of the environment were safe. Regular checks and servicing of gas and electrical equipment were conducted, and the water temperature of baths was checked before people used them. Equipment used to support people to move, such as bath hoists, was also checked and serviced regularly. There was a process in place to check fire safety equipment on a weekly, monthly or yearly basis, as required, and staff had received recent fire safety training. They spoke enthusiastically about this, which had included using fire extinguishers, and were aware of the correct action to take in the event of a fire. Personal emergency evacuation plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency and staff had been trained to administer first aid.

At our last inspection, we identified that individual risks to people were not assessed and mitigated. During this inspection we found that people were protected from harm in a way that supported them appropriately and respected their independence. Staff had assessed the risks associated with providing care to each person; these were recorded along with actions identified to reduce those risks. For example, people who were at risk of falling had risk assessments in place in respect of the support staff should offer to help them mobilise safely. During the inspection we observed staff monitoring people and offering support in line with their risk assessments. One person had developed an infection that was resistant to antibiotics. Staff put appropriate procedures in place to prevent the spread of infection; they also alerted visiting professionals to the risk and provided personal protective equipment for them to use.

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. These included referring people to the falls clinic (via their GP). One person had experienced three falls. After each fall, their risk assessment was reviewed and additional measures introduced to protect the person. These included the use of soft mats by their bed and devices to alert staff when the person moved to an unsafe position. They had also been referred to the mental health team, who conducted a range of tests. These identified the underlying reason for the falls, which was being treated. The provider analysed falls across the home on a monthly basis to identify any trends or patterns. This showed the number of falls had reduced significantly over the past year. The analysis identified key times when people were more likely to fall; this had led to the introduction of room checks by staff to check people were safe at these times and offer additional support if needed.

People told us they felt safe at the home. One person said, "I feel safe because the staff are absolutely marvellous." Another person told us, "I'm happy here, the atmosphere is good; there's no trouble and I feel safe." A community nurse said, "[People] seem happy and there always seems to be [staff] around." Staff had the knowledge and confidence to identify and report safeguarding concerns, and acted on these to keep people safe. Staff told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. They were also aware of external organisations they could contact for support, including the local safeguarding authority. Where safeguarding concerns were identified, senior staff conducted thorough investigations and took action to keep people safe. A social care practitioner from the local safeguarding team confirmed that staff engaged with them and reported concerns appropriately.

There were enough staff to meet people's needs. We saw that staff were not rushed and responded promptly and compassionately to people's requests for support. The registered manager told us staffing levels were based on the needs of people using the service and feedback from people and staff. When setting the staffing rotas, they also took account of the skill mix to help make sure staff with the necessary skills were available throughout the day. A nurse practitioner who had frequent contact with the home told us, "Safety is always a concern [of the registered manager]. If a resident needs one to one care then that is provided."

Robust recruitment processes were followed and staff were checked for their suitability before being employed by the service. Staff records included an application form, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. Each staff file also contained a full employment history for the applicant; these had not been available at the last inspection, but were now in place and fully completed. To further enhance the process, the operations manager told us they had started keeping records of candidates' responses to interview questions, so they could refer to them in future if

needed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2015, we identified a breach of regulation as staff did not always understand or follow the Mental Capacity Act, 2005 (MCA) or its code of practice. The provider wrote to us detailing how they would become compliant with the regulations. At this inspection we found action had been taken although some further improvement was needed.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that where people lacked capacity to make decisions, staff completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines and the use of bedrails. However, for two people we noted that the MCA assessments did not specify the decisions in question, and had each been used as the basis for two best interests decisions. This was unlikely to have affected the outcome for those involved and the operations manager took action to help ensure that an assessment was completed for each relevant decision.

Some family members had lasting powers of attorney (LPA) in place to enable them to act on behalf of their relatives. Staff told us they asked relatives about these, but did not always view them, or take copies, to assure themselves about the extent of the authority that had been granted. We discussed this with the operations manager, who took immediate action to obtain copies of all LPAs to help ensure they did not ask family members to make decisions for people beyond the scope of their legal powers.

We observed that staff asked people for consent from people before providing them with care or support. Unless there was evidence to the contrary, staff assumed people had capacity to make decisions and recorded this in their care plans as a reminder to staff. If people were not able to sign their care plan, staff documented their comments to confirm that they were fully in agreement with the care and support that was planned.

One person was receiving their medicines covertly. This is where a person's medicines are hidden in a small quantity of food to make sure they receive them. Staff had assessed the need for this, in line with the MCA. They had also consulted with the person's family members and health professionals, including the pharmacist, to check the medicines were safe to administer in this way. In accordance with best practice guidance, staff attempted to administer the medicines in an open way first, but if the person declined to receive them, staff gave them covertly to help keep the person well.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being

met. We found the provider was following the necessary requirements. DoLS authorisation had been approved for one person and applications had been made for a further five people. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. The operations manager described the process they used to constantly review DoLS authorisations to check they were still needed. For example, they recognised that one person's need for a DoLS authorisation was due to a temporary medical condition. They said once this had been treated the person might no longer need the DoLS and they would apply to have it removed.

People's needs were met by staff who were skilled and suitably trained. One person told us, "Staff are very good and look after me well." Another said, "I'm happy and comfortable here and well looked after." A family member described the quality of care as "excellent". A nurse practitioner, who had frequent contact with the home told us, "The staff are encouraged by [the registered manager] to develop their skills and knowledge, which gives them the ability to deliver high standards of care effectively."

Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, one staff member requested extra training in dementia and received it. When we talked to them, they showed a good understanding of how to support people living with dementia. Staff were also supported to obtain vocational qualifications relevant to their roles. Most had obtained level two or level three qualifications, whilst senior staff were working towards level five diplomas to develop their supervisory skills.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. A new staff member told us, "The induction covered everything I needed it to; it was brilliant." Arrangements were also in place for staff who had not worked in care before to undertake the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for one of the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff also received support through less formal methods; for example, they told us the registered manager often called then when they were working at night to check they were okay and that they understood people's needs. The registered manager said, "I spoke with [one staff member] recently and was impressed with their knowledge of diabetes. It was really good." Staff who had worked at the home for over a year had also received an annual appraisal with one of the management team to assess their performance and identify development objectives. Although some of these were overdue, the operations manager had a plan to complete them all in the near future. Staff told us supervisions and appraisals were helpful and spoke positively about the support they received from managers on a day to day basis.

People praised the quality of the food and said they enjoyed all the meals. One person said, "The food is very good." Another person told us, "The food and company is good here." A family member confirmed this and said, "[My relative] says it's the best food he's ever had."

Staff were all aware of people's dietary needs and preferences, which were clearly recorded in their care plans. The dining room was welcoming and tables were attractively laid out with tablecloths and fresh flowers. The chef spoke with people in the morning about what was on the menu that day. If they did not want the menu of the day, the chef was happy to make something different. One person was happy with the main menu option but requested a small portion, which they received. When it was served, it was slightly delayed as the staff member had put gravy on it and then realised that the person didn't like gravy. They

explained the delay to the person and arranged for a new meal to be prepared without gravy.

Staff were attentive to people, offering them additional portions and encouragement to eat. People on special diets received these as needed. For example, after taking the blood sugar levels of people with diabetes, if the readings were high, staff alerted the cook to the need for low-sugar options to be made available for those people. One person needed full support to eat and received this in a calm and dignified way. Three people needed their meals pureed and we saw these were presented in a way that allowed them to distinguish the individual food items. One staff member described how they encouraged a person to drink. They said, "[The person] will often say 'no' to a drink, so I stop. It's her choice. But then I approach her again and offer to freshen up her drink and she says 'yes please' and then drinks it. Afterwards, she always says 'thank you, I feel much better'."

Staff monitored people's weight on a monthly basis. If unplanned weight loss was identified, staff took appropriate action. This included closer monitoring of the person's intake, through the use of food and fluid charts, and referring the person to their GP for advice.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. A family member told us, "[Staff] got [my relative] into the local surgery and since arriving has been seen by specialist after specialist." A community nurse said of the staff, "They always contact us if they have any queries; I'm confident that they follow our advice and come back to us if needed." This was confirmed by a nurse practitioner who told us they visited the home several times a week and worked well with staff.

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. Comments from people included: "Staff are very good, we're very lucky"; "I enjoy living here, it's nice and friendly"; and "Staff are very good and very friendly". A family member echoed these comments and added: "We can relax, knowing [our relative] is being looked after and is happy." A nurse practitioner who had frequent contact with the home told us, "It's a friendly and lively home. The staff are genuinely caring to all the residents."

We observed positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. Staff spoke about people warmly and demonstrated a detailed knowledge of them as individuals. One staff member told us, "It's a lovely home; there's a real family feel. We've lost residents recently and it leaves a real dent. We really miss them."

When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. They also spent time engaging with them at eye level and using supportive communication techniques. For example, one person indicated that they thought it was mid-summer. Rather than challenge this, the staff member moved the conversation forward by talking about Halloween. They then said, "And after that there's fireworks night and before you know it, it'll be Christmas." This helped orientate the person to the current season in a positive way.

People's privacy and dignity were protected. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. Staff knocked and sought permission before entering people's rooms. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. A staff member told us, "[People's] ability changes from day to day, so I always check if they can do it by themselves or if they want some help." People's care plans encouraged staff to promote people's independence. For example, one person's care plan stated: "When dressing me, use gentle stroking action on each limb first; it may prompt me to complete the action." After lunch a staff member identified that one person had not drunk very much. They refreshed the person's drink and spent time supporting them to hold the beaker on their own and encouraging them to drink from it. This helped them retain the skill and their independence.

People were supported to follow their religion. Representatives from local churches attended weekly to distribute Holy Communion to those who wish to receive it. In addition, a church service was held each month, which was well-attended.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives.

Good

Is the service responsive?

Our findings

At our last inspection, in August 2015, we identified a breach of regulation as people's care records were not complete or accurately maintained. The provider wrote to us detailing how they would become compliant with the regulation. At this inspection we found the provider had introduced a new, computerised care planning service. This had been used to develop comprehensive care plans for each aspect of people's care.

The care plans provided advice and guidance to staff about how they should meet people's needs, including: medicines; continence; skin integrity; nutrition; personal care and mobility. People living with dementia also had a 'dementia care plan' detailing the support they needed with daily tasks, such as making choices, communicating, and eating. For example, one care plan said the person "can work through tasks if carers use single words, gestures and physical prompts. When communicating, use facial expressions and touch." We saw and heard staff using these approaches throughout the day.

The care plans were centred on the needs of each person and detailed their normal daily routine, their backgrounds, hobbies, interests and personal preferences. For example, they specified whether people preferred baths or showers and how often they liked to receive them. They also indicated when people preferred to get up and go to bed. Records of daily care provided confirmed that people received care in a personalised way in accordance with their individual needs.

Staff spoke positively about the care plans and said they provided all the information they needed to enable them to meet people's needs. They demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support. For example, which people drank well, who needed encouragement and where people chose to spend their day. A social care practitioner, who had been working with the home, told us, "The care plans are now really good."

Reviews of care were conducted each month. Any identified changes were updated in the person's care plan, and communicated to other staff, to help ensure people's current needs were met. A staff member told us, "Every month, [two senior staff members] do updates. We all discuss people together and come up with the best plans for people." Records showed that people and their relatives were also consulted as part of this process.

People told us they received personalised care and support that met their needs. In particular, people spoke enthusiastically about the high level of activity provision they could access. They told us this had improved significantly since the last inspection and had had a positive impact on their lives. One person said, "I'm happy here; I enjoy flower arranging and do most of the flowers." Another person told us, "Staff take me for walks and I've been on a few trips which were good."

A family member told us, "The activities are fantastic. [My relative] never used to be very sociable, but he is now. There's entertainers and films and yesterday the floor was covered with toddlers and babies; [all the people] loved it." A staff member told us, "Activities needed improving and are much better now. People are

happier and smile more."

Staff had used information in people's care records to develop activity plans to suit their individual interests. Activities were primarily organised by an activities coordinator who had recently been recruited. They included trips to local attractions and coffee shops. On the day of the inspection, some people made Halloween pictures in the morning and watched a James Bond film in the afternoon. These were well attended and we heard people speaking positively about them. One person said, "I love the big TV and enjoy watching the films." The operations manager told us, "[The activities coordinator] has got people involved. When we do films, she gets lots of people to attend and sits with them to discuss it. The same when we have singers in; nearly everyone attends and it's a real event now."

People were able to choose which activities they took part in and suggest other activities they would like to undertake. These included arts and crafts, singing and dancing, exercise classes, flower arranging and film afternoons. The activities co-coordinator told us, "I try to see people in the morning for a one to one [session] in their room and have a chat to find out what activities they enjoy." They added: "Some of the men wanted a James Bond afternoon, so now on a Thursday we watch a James Bond film. When I asked them which Bond film they wanted, they told me 'all of them', so the home bought the whole back catalogue and we are [going through them all]." A gardening club had also been formed; some people had planted spider plants and were having a competition to see who could grow the biggest one.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. A staff member told us, "You pick things up by just listening to [people living with dementia] and get to know their likes. Even the little things are important, like choosing biscuits; we make sure they are involved and can choose them."

The provider sought feedback from people and their families in a variety of ways, these included the use of a suggestions box, questionnaire surveys and three monthly 'residents meetings' which were well-attended by people and their families. One person told us, "We had a meeting and we could say what we thought; I felt listened to." Feedback was used to help plan activities; for example, one person had asked to go to a local beauty spot where they could have ice creams and this had been arranged for them.

People knew how to complain about the service and the complaints procedure was prominently displayed. People and family members felt senior staff were approachable and that any concerns or complaints would be listened to and addressed effectively. One complaint had been received in the past year and we saw it had been dealt with promptly, in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2015, we identified a breach of regulation as the provider had not implemented a robust quality assurance system. The provider wrote to us detailing the action they would take to become compliant with these regulations. At this inspection we found the quality assurance system had been improved, but needed further time to become effective.

The quality assurance process included audits of infection control, the management of medicines and care planning. Following the audits, improvement actions were identified and implemented. For example, the cleaning audit had identified the need for more robust checks to be completed by the night staff and we saw these had been put in place. The medicines audit had identified the lack of dispensing labels on antibiotics and this had been addressed with the dispensing pharmacy. The audit had also identified that some pain patches were missing and this enabled an investigation to be commenced promptly and changes made to the way medicines were disposed of. However, the audit had not identified that the quantity of medicines in stock was not carried forward from one month to the next. Action had been taken to improve the risk assessment process, but the maintenance audit had not identified the lack of first floor window restrictors. Reviews of care plans had led to an improvement in their quality, although they had not identified that the Mental Capacity Act was not being followed fully. The systems, therefore, needed further time to become embedded in practice in order to work effectively.

Following the last inspection, we issued an overall rating of 'Requires improvement' to the service. Providers are required to display their ratings conspicuously on the premises and on their website. We saw the previous rating was displayed on a notice board in the office, but this could not be seen easily by people and their visitors. A check of the provider's website showed the rating was not displayed there. Whilst there was a link on the provider's website to the CQC website, where this information could be found, the link was not on the homepage of the provider's website and was not easy to find.

The failure by the provider to display the previous CQC rating conspicuously on their website and at the home was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had purchased a set of policies and procedures to help guide their practice. They were in the process of tailoring these to meet the needs of the home. They included a duty of candour policy, requiring staff to act in an open way when people were harmed. The registered manager followed this when a person fell and sustained a serious injury, by notifying the relevant family member by telephone. However, they did not follow this up in writing, detailing the circumstances of the fall, as required by the regulations. We discussed this with the operations manager; they said they had not been aware of the need to do this, but would ensure it was done in future.

People told us they were happy living at the home and felt it was run well. One person said, "The manager's very good." Another told us, "The [registered manager] is lovely and you can talk to [all the managers]." A family member said of the home, "It seems very well run and we are happy with it."

There was a clear management structure in place. This comprised of the registered manager, the operations manager and senior care staff. The operations manager stepped up to manage the home when the registered manager was not available; they also took part in an on-call rota to be available to provide advice and support to staff out of hours. Each senior staff member had responsibility for taking the lead on a particular aspect of the home, such as medicines or infection control. The registered manager was a member of the local care homes association. This helped them keep up to date with best practice guidance, as did private study and work that contributed to their re-validation as a registered nurse, which they had just completed.

Staff enjoyed working at the home and spoke positively about the management, who they described as "approachable" and "supportive". Comments from staff included, "I love working here"; "There's good team work, I feel valued and appreciated"; and "[The operations manager] is really good. She comes down and helps out, and we can always go to her if we had concerns. For example, a resident had [an allergic reaction] to their medicines and we got a good response from [the operations manager who was on call]". A nurse practitioner who had frequent contact with the home told us, "[Staff] always seem to be happy working there which helps maintain the homely feel." The registered manager told us they appreciated the contribution staff made to the running of the home. Following positive feedback in the provider's latest survey, the registered manager wrote to staff thanking them for their work.

Staff meetings were held regularly and provided an opportunity for staff to express their views and make suggestions for improvements. A staff member told us, "[The managers] listen and try to understand everybody." Another staff member confirmed this and said, "We all get our say. We are listened to and things do change; like I mentioned [an issue] and it was addressed; so the system works."

The registered manager told us the service's values were based on "kindness and dignity", which they considered were "really important". They told us they promoted these values through training and supervision. They said they also tried to set a good example by treating staff fairly and showing understanding when they had family problems that affected their work. We observed staff treating people with kindness and dignity throughout the inspection. When talking about end of life care, a staff member told us, "You only get one chance to get it right. The relatives will have lasting memories, so it's important to get it right, for everyone involved."

Positive links had been developed with the village community to the benefit of people. These included a local primary school, whose children visited twice a year and sung carols at Christmas; hosting the local 'mother and toddler' group every other month; and supporting people to attend a community group in the village. Work experience pupils from a local senior school also visited to spend time talking to people or helping with activities. In addition, the home took part in fund raising events for local and national charities. Feedback from people indicated that they enjoyed these events, particularly those where they interacted with youngsters.

A monthly newsletter was produced to keep people and their families up to date with events that had taken place or were planned. It highlighted people's birthdays and memorials to people who had passed away, together with changes to the staff team or initiatives the home were taking part in, such as charity fund raising events. Visitors were welcomed at any time and could stay as long as they wished. There were good working relationships with external professionals and notifications about significant events were reported to CQC as required.

The provider had plans to further develop the service. These included building links with a local bible study group; the purchase of lifting equipment to recover people from the floor after falls; the purchase of a

defibrillator; additional training for staff; and a possible extension to provide a larger space for hairdressing.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not ensured that the CQC performance rating was displayed conspicuously on their website and on the premises from which the service was provided. Regulation 20A(1) (2) & (3).