Majestic 3 Limited

Blenheim House Specialist Care Centre

Inspection report

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Date of inspection visit: 29 and 30 June 2015
Date of publication: 01/10/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 29 and 30 June 2015 and was unannounced. At the time of the inspection the service did not have a registered manager. However, the new manager in post had applied to the Care Quality Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Blenheim House Specialist Care Centre is a residential care home which provides nursing and personal care for up to 53 adults, some of whom are living with dementia. At the time of our visit there were 50 people living in the home.

Summary of findings

Blenheim House is a purpose built care centre located in Melksham on the edge of the Wiltshire countryside. The accommodation is set over three floors, residential, the Clover Meadow floor offering dementia care and the nursing floor. Each bedroom has en-suite facilities. There is a bar, café and cinema and lounges. There are two lifts to access the first and second floors. The gardens are landscaped with a pond and several seating and sensory areas.

Assessments of capacity and best interest decisions were not always recorded when people lacked capacity to decide on their care or treatment. The care records demonstrated that people's care needs had been assessed and considered their emotional, health and social care needs. However, there was a lack of recording and communication to evidence that people received safe care and treatment.

There were systems in place to ensure that staff received appropriate support, guidance and training through supervision and an annual appraisal. Staff received training which was considered mandatory by the provider and in addition, more specific training based upon people's needs. There was a focus on staff developing skills and knowledge; however we found that not all staff had the necessary level of language skills to be able to effectively communicate with people.

Not all care plans had been adequately developed to meet people's needs. On the nursing unit, the quality of recording was inconsistent or had not been completed.

People and their families praised the staff at Blenheim House for their kindness and the care they gave. We could see that people had developed caring relationships with staff and were treated with dignity and respect. People told us they enjoyed the surroundings of the home.

Staff had received training in how to recognise and report abuse. People told us they felt safe living in Blenheim House. There was an open and transparent culture in the home and all staff were clear about how to report any concerns they had. Staff were confident that the manager would respond appropriately. People we spoke with knew how to make a complaint if they were not satisfied with the service they received.

People took part in a range of one to one or group activities and the home were continuing to develop this part of the service.

The manager and provider carried out audits on the quality of the care delivered, the safety of the environment and all aspects of health and safety.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

At times, people told us they were not enough staff when they were busy.

People told us they felt safe living at Blenheim House.

Staff had received training in how to recognise and report abuse.

There were systems in place to ensure that people received their medicines safely.

Is the service effective?

Requires improvement

The service was not effective.

Mental Capacity Assessments and best interest meetings were not being carried out as required by the Mental Capacity Act 2005.

People were supported to have enough to eat and drink. Where required, people had access to specialist diets.

There were systems in place for staff supervision and appraisals.

Not all staff had the necessary language skills to be able to effectively communicate with people.

Is the service caring?

Good

The service was caring. Staff respected people's privacy and dignity.

End of life care plans were in place where required and staff told us they were confident in delivering care as the person wished.

People were involved in making decisions in how their care and support was delivered.

Is the service responsive?

Requires improvement

The service was not responsive.

There was a lack of recording which demonstrated that people received safe care and treatment.

People received care and support which was specific to their wishes.

People and relatives said they were able to speak with staff or the manager if they had a complaint.

Is the service well-led?

Good

The service was well led.

There was an open and transparent culture.

Summary of findings

The service had clear values about the way care should be provided.

There were systems in place to monitor the quality of the service provided.

Blenheim House Specialist Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 June 2015 and was unannounced. This inspection was carried out by three inspectors and an expert-by-experience. An Expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we asked the provider to complete 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 improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern.

We spoke with 16 of the 50 people living at Blenheim House Specialist Care Centre. We also spoke with ten visiting relatives about their views on the quality of the care and support being provided. We spent time observing people in the dining and communal areas. During our inspection we spoke with the manager, deputy manager and the nominated individual. We also spoke with 17 other members of staff ranging from a registered nurse, senior care workers, care workers, chefs, activity co-ordinator and the companion, housekeeper and laundry assistant, a hostess and the maintenance person. Before our visit we contacted people who visit the home to find out what they thought about this service. We contacted six health and social care professionals and received feedback from three.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of nine people, we looked at five staff training records, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Good

Is the service safe?

Our findings

There was a safeguarding and whistleblowing policy and procedures in place which provided guidance on the agencies to report concerns to. Staff had received training in safeguarding to protect people from abuse and training records confirmed this. Most staff were able to describe what may constitute as abuse and the signs to look out for. Staff demonstrated varying levels of knowledge and understanding with regard to safeguarding and whistleblowing. We refer to this further in the effective domain.

People told us they were satisfied with how they received their medicine and generally knew what the medicine was for. We observed one person being given their medicine. The member of staff told the person what the tablets were for and waited until they were sure that the person had taken their medicine successfully. Staff administering medicines wore a red tunic to make staff and people aware that they were not to be disturbed during this time. On each floor, medicines were stored in the medicines room in a lockable cabinet which only certain members of staff had access to.

One medicine record had not been correctly completed during the morning handover and showed more tablets in stock than was held. Once the error was highlighted to the deputy manager, they followed this up immediately. All other records were accurate and complete. There were protocols in place for the administration of medicines that were prescribed on an 'as and when needed basis' (PRN medicines).

Nursing and senior staff had responsibility for administering and disposing of medicines and undertook training and competence checks to ensure they remained competent to deal with medicines. Medicines were recorded using an electronic system and the disposal of medicines was recorded electronically. Prescribed medicine was disposed of in a large yellow box with a lid, however we were able to open the lid and access the drugs listed as destroyed. We raised our concern with the manager that the contents could be removed having been recorded as having been destroyed. They told us they would follow this up immediately and purchase secure disposal boxes.

People told us they felt safe and comments included "I feel very safe here I don't find many problems and people treat me kindly" and "It seems to be very safe here because you can always find somebody to talk to. Before this I was living on my own and I was having falls. I was worried that one day I would fall and be left on the floor without help. This is so much better". A relative did raise concerns about other people walking into their family member's room without being invited and said they had raised this with the management team. People told us that they had not experienced any form of discrimination relating to their physical or mental condition and that they were treated fairly by staff.

Safeguarding records evidenced that the manager took appropriate action in reporting concerns to the local safeguarding authority and acted upon recommendations made. Notifications were made to the Care Quality Commission (CQC) as required. There was a low level of incidents or accidents occurring within the home and the records showed that following incidents or accidents, risk assessments were updated or put into place.

Risk assessments were used to identify what action needed to be taken to reduce potential risks which people may encounter as part of their daily living. The risk assessments formed part of the person's care plan and gave guidance to staff on how care and support should be delivered to keep people safe and to enable them to maintain their independence.

During our inspection we found that call bells were answered promptly and people received care in a timely manner. On the second day of our inspection we visited the home at 7 am. On all floors we found there were sufficient staff to support people's needs. However, during the inspection we did find it difficult at times to locate a member of staff as they were busy.

There was a mixed response from people regarding the level of staffing. Some people were very happy and said you could always find a member of staff, other comments included "Usually there is someone to help you but at certain times, such as when they are helping people out of bed, you do have to wait" and "'On one occasion I slipped off my chair and was down on the floor. Eventually a carer came and pushed the emergency button and it was ages before any more help arrived. An emergency is an emergency surely people should come running. But the manager was concerned and spoke to everyone".

Good

Is the service safe?

Most staff felt there were enough staff however some felt they were times when they were particularly stretched. Healthcare professionals told us there times when they visited that it was difficult to find a member of staff.

The home was well maintained and safe throughout. The layout of the building promoted people's independence, dignity and safety. The communal areas of the home were clutter free, spacious and accessible for wheelchair users. We saw people moving around freely, either independently or in their wheelchair.

There were effective recruitment procedures in place which ensured people were supported by appropriately experienced and suitable staff. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

Blenheim House specialist care centre is purpose built and in terms of infection control it has been designed with laminate flooring and wet room areas in order to reduce the risk of infection and to help reduce odours. The building was very clean and odour free, making for a pleasant environment for staff, residents, and relatives.

A member of the housekeeping team spoke knowledgeably about their Control of Substances Hazardous to Health (COSHH) training and the cleaning schedules they followed. The cleaning trolleys were divided into sections for low risk areas, room floors, dining, lounge and kitchenette areas and high risk areas such as en-suite and communal bathroom/toilet areas. Mops and cloths were appropriately colour coded to help reduce cross infection. Staff had received appropriate infection control training, such as correct hand washing techniques. Hand sanitising gel dispensers were full and were placed at strategic points throughout the Home. Hand washing facilities were well stocked.

Equipment such as lifting hoists, wheelchairs and electrical equipment had been fully tested and labelled with the test date. This ensured that equipment continued to be safe to use. Each person who required the use of a hoist, had their own personal hoisting sling to prevent the spread of infection and all slings were clean and in working order.

The provider had risk assessments in place for the environment and facilities, such as ensuring that the water systems were regularly checked for legionella. [Legionella is a disease which is caused by bacteria in water systems]. Staff had received training in fire safety and health and safety. Fire equipment was regularly tested and there were personal evacuation plans in place for people in the event of a fire. Should the premises need to be vacated in an emergency, alternative accommodation and transport had been arranged for people. A risk assessment was in place for the pond in the garden at the back of the property. At the time of our inspection, the pond was uncovered which posed a risk to people or visiting children of drowning or injury. The manager confirmed that the pond was to be covered with a decking to reduce the risk of harm and this was to be completed by August 2015.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards is part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make a certain decision and there is no other way to look after the person safely. The manager had applied for Deprivation of Liberty Safeguard (DoLS) where this was applicable to individual people in relation to their freedom of movement and care welfare.

On the first day of our inspection we were told that one person was being moved from their current room to a smaller room. This had been discussed and agreed with the person's relatives who had 'power of attorney regarding their social care as the person did not have the capacity to make the decision themselves'. Within the person's care records there was no documentary evidence that a best interest decision had been made in line with the Mental Capacity Act 2005, Code of Practice. In addition, there was no evidence that the home had tried to encourage the person to give their view and consent.

Within some of the care records we looked at, signatures had not been obtained for capacity assessments or documentary evidence that families had been involved where they held power of attorney. For one person there was confusion over their capacity. In the pre-assessment it stated they did not have capacity but did not state in which area they lacked capacity. In this person's care plan, it stated the person could communicate verbally, however the 'Do Not Resuscitate form' had been signed by a relative who had Power of Attorney. There was no evidence of how the home had assessed this person capacity to make this particular decision and how they had tried to engage them including following a best interest process.

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

Staff received mandatory training as set by the provider and specialised training as required. The manager explained that not all staff received the specialised training but were given guidance, information and instruction by senior staff that had. People told us "I feel that the carers know what they are doing and seem to do everything right. I have every faith in them" and "there are many very good staff here, lots of training". A relative said "I come in regularly and I know that they look after my family member very well when I am not there".

Staff had received basic dementia awareness and behaviour management training. Care staff we spoke with knew people well and were able to tell us the level of care each person required.

We spoke with some members of staff where English was not their first language. We found they did not have an adequate grasp of the English language in order to sufficiently understand and converse with us. Therefore, we were not able to ascertain if these staff were knowledgeable about the topics we raised and were therefore competent in their skill base. This was in relation to Safeguarding, the Mental Capacity Act, Deprivation of Liberty Safeguards, Whistleblowing and terms such as supervision and appraisal. During the interviews we rephrased our questions in different ways, but were not successful in communicating the questions.

We looked at the training records of these staff which evidenced that training had been successfully completed in the above subjects. Training was carried out by watching DVD's in English with some face to face training. The manager told us these staff had undergone and continued to take classes in English as a second language. However, the manager could not demonstrate how they had assured themselves the staff understood the training and had the knowledge and skills required. Relatives and people told us that sometimes it was difficult to understand what staff were saying to them and sometimes they had difficulty in making staff aware of what they were saying or wanted.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff undertook a six month probationary period in which they completed an induction. The induction included looking at care plans, completing the mandatory training, familiarising themselves with the service's policies

Is the service effective?

and procedures and shadowing more experienced staff members. All new staff were completing the Care Certificate which is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff supervision took the form of one to one meetings with their line manager or group meetings. The manager told us that supervision had fallen behind and there was an action plan in place to address this and annual appraisals. Most of the staff we spoke with had received a recent supervision; however some were waiting for a supervision date.

Care records evidenced that referrals were made to appropriate health professionals when required so that people could access healthcare. This included visits from the GP, mental health team, tissue viability nurse, continence support and speech and language therapy. Hospital appointments and services such as dental and optical care were accessed with relatives or with staff supporting people to attend appointments.

People told us the food was very good at Blenheim House and the chef was around to check things and often asked them about the quality and taste of the meals. Comments from people included "The food is very good here and if you don't like what is on offer then the chef will get you what you want", "'He [the chef] is the first person to get me on a diet. He is brilliant really. He prepares and cooks the sort of food that I need but wouldn't normally eat, no chips and burgers, shame but I have lost a bit of weight" and "I'm really enjoying the food, just the sort I like and there is plenty of it". A relative said "I come in and eat with my family member sometimes. We can have a nice meal in the Brassiere where it is quiet. The food is good".

The in-house café was used as a social meeting place and provided people and relatives with a quiet, relaxing space. Drinks, fruit, cakes and jellies were available, free of charge, and relatives told us how much they appreciated the facility. There was also a bar where people could socialise.

Snacks and hot drinks were provided at regular intervals throughout the day and people told us that if they wanted a snack or a hot drink then staff would get what they asked for. People also had access to drinks in their rooms and each room had a small refrigerator and a kettle so they could make drinks. However, one person told us they could not use the kettle as they could not carry it when it had water in it.

People with special dietary requirements, including those who have medical conditions or who require soft or pureed meals were catered for. Information was gained through regular meetings with management and nursing staff. The chef said people were regularly consulted on their likes and as far as possible he took their suggestion into consideration when devising menu plans. Allergen advice was provided and used to ensure people with food allergies were protected from potential harm.

On the both days of the inspection, the external temperature was approaching 32C and health alerts had been issued. The manager had responded by giving increased priority to hydration. Throughout the day staff dispensed tea, coffee, ice-lollies and a range of cold squashes. They encouraged people to drink by constantly offering sips of liquid. Meal times on the Clover Meadow unit and the residential unit were a social event. Dining areas were well laid out in a user friendly way. We observed staff showed people the meals which were on offer so that they could make a choice. However, people and their relatives told us they would like a written and a picture menu to be available so they could consider what to order in their own time. Relatives told us this had been raised with the manager but so far 'nothing had been done'.

People were supported to eat and drink and staff asked people if they would like help with their meal. Pureed meals were well presented in quenelle style, with each vegetable and meat course separated. Support was given to people who were unable to leave their rooms or chose to eat in their rooms. Hot meals were brought to them and the small number of people who needed help with eating and drinking were supported sensitively.

On the nursing unit we found people were not encouraged to use the dining room. The tables were not set for lunch; there were no cutlery or napkins in place. There were 15 people currently receiving care in the nursing unit; however we saw only three people ate in the dining room. We discussed this with the manager.

The design and layout of the building promoted people's independence and privacy. The home was purpose built on three levels. Internally, the accommodation had wide access doorways and easy glide non- slip flooring with space for people to move around freely without obstruction. Communal areas were bright and hallways were wide and straight which meant that people could

Requires improvement

Is the service effective?

walk unsupervised without the risk of knocking themselves on protruding walls. There were hand rails on the walls throughout all of the communal areas. In addition, bathroom and toilets had grab rails for support.

The garden area was well laid out with shaded areas and sensory gardens. One person said “I really enjoy the garden. I get out as often as I can. The flowers are beautiful and I love the shaded areas”. People said they enjoyed using the garden areas for recreation. On each level people had access to a glassed balcony/terraced area which was furnished with good quality patio tables and chairs.

Good

Is the service caring?

Our findings

People who live at Blenheim House and relatives told us that Blenheim House was a 'caring place'. People commented “staff are very caring and I get good care here”, and “they [the staff] are wonderful, very kind”.

A relative said “sometimes I get really upset and find myself sobbing uncontrollably. The girls are so wonderful. They help me so much” and “‘very kind and caring staff here. It was so nice that the kitchen made a big cake and invited carers, residents, staff and friends into the garden for a party, to thank all the carers for their hard work and their contribution, as part of National Carers Day”. Another relative commented “I am very satisfied with my mum's care so far. The carers are very caring and know how to look after her well”.

Staff were respectful towards people and interacted with a kind and compassionate approach. People and staff had formed positive relationships and people looked content in the company of staff. Staff responded as promptly as they could when people requested assistance and they did so in a patient and attentive manner. We observed many examples of person centred care, with staff taking time to support people in a way that made them feel valued. We observed that one person with advanced dementia, looked very disorientated. The carer saw what was happening and talked calmly to the person. They reassured him and gently guided him to where he was heading for.

On many occasions we observed staff were careful to ask people before delivering any form of care. For example, at lunch time staff always asked people if they would like a covering napkin. A nurse carefully explained to one person what their medicine was for and how it should be taken. One person said ‘I’ve been asked about the sort of care that I need and how best it can be delivered by members of staff”. Relatives told us they were consulted about their family members care and were involved in decision making if it was appropriate.

Staff delivered discreet care in a way that allowed people to maintain both their dignity and self-esteem. Staff respected people’s privacy and dignity by knocking on their door and waited for a response before entering. People received personal care in the privacy of their own room and doors were shut when people received care. Staff spoke warmly about people which indicated they held them in high regard. They had a good knowledge of individuals and knew what their likes and dislikes were.

End of life care plans were in place for some people. The manager told us they were developing end of life care plans when required and as people made their wishes known. Staff had received training in end of life care and felt competent and confident in delivering care and support in the way people wished.

Requires improvement

Is the service responsive?

Our findings

We observed that people looked well cared for and staff demonstrated a good knowledge of their care needs. However, the care records did not accurately reflect the care being provided or required. As a result, we were unable to ascertain if people were receiving appropriate and safe care and treatment.

A visiting healthcare professional expressed their concern around paperwork such as charts being difficult to locate and information not being communicated between the staff.

We observed one person with advanced dementia and who had limited verbal communication, was looking quite frail. We shared our concerns with a member of staff who noted the person's weight chart had shown a considerable weight loss over a short period. The person was not being supported with fortified food as a means of managing their weight loss.

Care plans had not been adequately developed to meet people's needs. On the nursing unit, the quality of recording was inconsistent or had not been completed. One person was assessed as being at risk of pressure ulceration. To reduce the risk, staff were to encourage the person to change their position every two hours. The guidance also stated that potential pressure areas were to be assessed at least twice a week. There was no documentary evidence the guidance was being followed and the person was receiving the care required. There were no positional change charts in place.

Within another person's care plan it stated they were to be repositioned every four hours, we found there was no repositioning chart in place to record this. In addition, there were no daily records to indicate if this person had been out of bed or used their wheelchair for a twenty day period. (spending long periods of time in bed without repositioning increases the risk of pressure ulceration). Six people, who stayed in bed in the nursing unit, did not have charts in place to ensure monitoring of care and support such as repositioning, fluid intake or hoisting.

We asked a member of staff why one person did not have a chart in place to monitor repositioning. They told us the person did not need to be repositioned. However, this person's care plan stated that the person could not walk or stand and had to be hoisted. They had health conditions, one which limited their movement on the left side and they were a wheelchair user. We spoke with the deputy manager who put a turning chart into place on the afternoon of the 29 June 2015.

Not all care plans had been updated to reflect people's care needs. For one person who was initially assessed as being at 'some risk of pressure damage', the review of their care plan on 5 June 2015 stated the care plan remained current. However, by June 2015, their water low score had increased to a high level of risk from 13 to 20. (A water low score gives an estimated risk for the development of a pressure sore in a given person). The pressure sore grade went from a grade one to a grade two. Entries on the wound care record were not being completed as required and repositioning was not routinely being recorded.

Risk assessments were not being followed by staff. For one person there was a falls risk assessment in place which had assessed their risk of falls as high. The risk assessment stated that the floor should be kept free from hazards, yet we saw wires from electrical equipment on the floor plugged into an extension lead, the wires were not arranged together and put out of the way to prevent the risk of trips.

We observed a carer pushing a person in a wheelchair without the foot plates in place. They told us that this person did not like them to be used. The risk assessment stated that when staff mobilised the person, the foot plates should be in place at all times.

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

People's individuality and characters were acknowledged by staff who knew the likes and dislikes of people well. Peoples wishes were fully respected and personal preferences were supported by staff, such as what time they chose to get up and go to bed, what they wanted to wear that day and how they wanted to spend their day.

A full time activities co-ordinator was employed and supported by a part time (20 hours) assistant. . Additional support was provided by people from the community, such as a visiting artist, a PAT dog handler and local choirs. Within the home there was a Café and Bar where people socialised with family and friends. There was a cinema, hairdressing and a therapy room. The garden was large with many seating areas and people told us they enjoyed

Requires improvement

Is the service responsive?

being out in the garden. People who enjoyed gardening were able to plant flowers and maintain the flower beds. People were supported to attend church either through the visiting clergy or by visiting their own place of worship. There were visits from local police officers who socialised with people by chatting and playing a game of billiards.

The activity co-ordinators had a clear plan to develop activities to include an arts and craft room and a sensory room. They were in the process of extending the range and number of activities. Trips out to local garden centres, shops and the weekly bus mystery trip are popular with residents who enjoy going out. These were as inclusive as possible. People spoke highly of the larger events that had taken place such as Carers' Day and they were looking forward to the Summer Fete. The manager told us they were continuing to develop the activities on offer. Having spoken with people, some felt there was not enough to do.

On the nursing unit we found many people stayed in their room. Staff told us it was difficult to get people to leave their room to use the dining room or the communal areas. People in the nursing unit told us that sometimes staff did not have the time to sit and chat. A companion role had been created in order to support people who found accessing activities difficult. This goes someway to helping to prevent some people from becoming socially isolated. The companion, in discussion with other staff members, will identify people who could benefit and will spend an unspecified amount of time with them. This role included spending quality time with people such as local community visits or visits to the garden The Home was considering the possibility of employing another companion.

People's rooms were individualised; they commented on how they were encouraged to bring in photographs, ornaments and small items of furniture and memorabilia and were able to arrange the room as they wanted.

Copies of the Providers complaints procedure were clearly displayed in brochures in the entrance of the home and people told us they knew how to raise concerns or make a complaint. People told us that generally complaints were taken seriously and action was taken to resolve the matter although some people and relatives felt the management did not always listen or take concerns seriously when they initially raised concerns.

Good

Is the service well-led?

Our findings

The manager of the home had started their employment with the provider in November 2014. There was a delay in processing their application to become the registered manager, however, since the inspection the manager had undergone an interview to become the registered manager and was awaiting the outcome.

The service had clear values about the quality of service people should receive and how this should be provided. The manager told us "Since I started at the home, there have been a lot of staff changes. Those staff who have stayed are committed to the home and prepared to learn and develop and I can see improvements". A member of staff said "The manager is very keen for staff to move forward and go that extra bit to extend their professional qualifications. She will support you in this".

A carer described the ethos and values of the home "as a place where carers actually care, know their residents and take that extra bit of time, a new life, new beginnings". Another carer commented "I love this job and the difference I can make to people's lives". Staff told us they felt valued by people and 'always got a thank you'. Other staff told us that the management team gave staff praise and a thank you for their work.

Relatives, people and staff said they felt the service was open and transparent. The majority of staff felt valued by the management team, however, some staff said they did not feel listened to.

A relative told us "I wanted my mum to come here; people told me they knew that the managers had a visible presence around the home". The home received compliments from relatives and people with one relative commenting "The team looked after my mum brilliantly".

The manager told us they were very well supported by the provider and met with their line manager regularly to discuss the homes development plan and all other areas of running the home. There were regular meetings held with other location managers and within the home regular staff meetings. People and relatives had an opportunity to voice their views through 'resident and relatives' meetings.

In the summer of 2015, the home held a staff BBQ in recognition for their hard work and commitment. In 2016, a new scheme for 'employee of the month' was to be introduced as a way of further showing the provider's support and recognition of staff achievements. In addition, the provider holds an award ceremony where presentations were awarded to staff who had completed qualifications, long service or who had shown enhanced leadership in their role.

The service had a development plan in place, which brought together all of the actions needed. The manager had spent some time in the recruitment of new staff and they now had full recruitment of the nursing team. The focus for the future was on developing staff skills within the team, cascading the leadership down and empowering the whole team to feel they had an input into the home. The new fundamental standards had been introduced to the team and lead roles to date were dignity champions, dementia friends, infection control and mental health. Other roles were being planned. There were plans in place to further develop the accommodation, one example being to have a pub on the premises.

The format of the care plans were being changed with a view to them becoming electronically accessible to staff via an I Pad.

The provider was developing their dementia strategy through continuing to access the University of Stirling resources and training in improving dementia care. The home had a Stirling qualified facilitator who involved staff in developing their knowledge and skills in dementia care.

We discussed with the manager how staff used information to ensure a holistic approach to people's care and support and how they could ensure a sufficient level of leadership on the nursing unit. These were areas which had been identified by the manager for development and the introduction of the electronic care plan and monitoring system and the recent recruitment of a permanent nursing team should resolve these issues.

The manager submitted statutory notifications to the Care Quality Commission as required. The service worked in partnership with key organisations to support the provision of joined up care such as health and social care teams. The home had links with the local community such as churches, voluntary organisations, schools and the local

Good

Is the service well-led?

authority. Resources, research, best practice and other information was obtained through the company's quality assurance and clinical governance team, and access to appropriate websites.

The provider had a system in place to monitor the quality of the service. This included monthly and quarterly audits completed by the manager and monthly checks by the regional manager. The audits covered areas such as health and safety, staff training, supervision and appraisals, care plans, management of medicines, incidents and reporting on the levels of falls, pressure ulceration, and behaviour management. The audits highlighted areas for improvement and development. Quality and clinical audits were linked to the fundamental standards and the provider's policies and procedures had been updated to reflect the new legislation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Mental Capacity assessments and best interest decisions were not carried out in line with the Mental Capacity Act 2005, Code of Practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Some staff did not have the necessary language skills to be able to effectively communicate with people and demonstrate their level of skills and knowledge of care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The care records did not accurately reflect the care being provided or required. Records were incomplete, missing or lack sufficient detail. Risk assessments were sometimes not followed so that people received safe care and treatment. Records were reviewed in isolation and there was a lack of communication between staff.