Care Quality Commission

Bindon Care Ltd

Bindon Residential Home

Inspection report

32-42 Winslade Road
Sidmouth EX10 9EX
Tel: 01395 514500
Website: www.bindoncare.com

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Ratings

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

Overall summary

An unannounced inspection took place on 5 and 9 November 2015. It was carried out by two inspectors. Bindon Residential Home provides accommodation for up to 46 people and 36 people were living at the home during our visit. The service provides care for older people; most people are living with dementia. The building is separated into two different areas called Bindon and Elmcroft, which are accessed by two separate front doors or the via the garden.

A registered manager was in post. 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 Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict

Summary of findings

their freedom in some way, usually to protect themselves or others. At the time of the inspection, applications had been made to the local authority in relation to most people who lived at the service.

There were numerous positive interactions between staff and people living at the home; we saw staff treated people with kindness and compassion. It was evident staff were aware of people's life histories and knew their preferences for how care and support was to be provided. Staff understood the need to respect people's privacy and maintain their dignity. People looked confident as they moved around the home and people told us they felt safe. Staff knew to report poor or abusive practice. People had access to health services.

There were times when there were delays in assisting people or monitoring the impact of people's behaviour on others. The provider is currently recruiting for staff to specifically provide activities; some people said they would like more to do. Staff were provided with a range of training and were able to translate theory into practice. The service was run by a registered manager, who staff described as approachable.

Risk assessments and care plans did not consistently reflect people's current support and care needs and at times lacked guidance for staff. Staff were attentive and provided individualised care. Staff understood the importance of gaining consent. People benefited from a staff group that were trained and worked as a team.

Improvements were needed to the recruitment and some aspects of the quality assurance process to make them more effective and help keep people safe. Medicines were administered safely but changes were needed to improve the auditing of medicine management. Once the management team were aware of a complaint they took time to try to resolve the concern and work with people and their families. However, current information regarding making a complaint was not accessible or clear regarding the process and timescales.

We found a breach 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?

Requires improvement

Most aspects of the service were safe.

Some aspects of recruitment needed to be improved.

Some areas of risk management needed to be improved to ensure risks were managed safely and consistently.

There were times when there were delays in assisting people or monitoring the impact of people's behaviour on others.

Medication was administered safely.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Is the service effective?

Good

The service was effective.

People were supported by committed staff who were trained to meet their emotional and health care needs.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered.

Staff received support to develop their skills and ensure they were competent in the work.

People were supported to access healthcare services to meet their needs.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind, caring, considerate and understood their needs.

We saw interactions between staff and people who used the service that were enabling, comforting and supportive.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

There was a complaints process but written information was not readily available about the process and the timescales.

People's care needs were reviewed but not in a meaningful way which resulted in care plans not reflecting their current needs and the risks to their well-being.

Improvements were needed to meet people's social needs.

Summary of findings

Staff recognised changes in people's health and well-being and reported these appropriately.

Is the service well-led?

Most aspects of the service were well-led.

Quality monitoring systems were in place but some audits had not identified areas for improvement, including recruitment.

Staff were supported by an approachable manager.

Requires improvement

Bindon Residential Home

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 took place on 5 and 9 November 2015 and was unannounced. There were two inspectors. One inspector used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not comment directly on the care they experienced. An expert-by-experience was also part of the inspection; 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 our inspection, we reviewed the information we held about the home, which included the provider's pre-inspection information return and incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

During our visit we met with 22 people staying at the home and spoke with 18 people about their experiences of care. We met with seven visitors who shared their views with us. We met with seven staff who carried out a range of roles within the home, and also spoke with the registered manager, the operations manager and the provider. We looked at records which related to five people's individual care, including risk assessments, and people's medicine records. We checked records relating to training, supervision, complaints, safety checks and quality assurance processes. We looked at four staff recruitment files. We spoke with a social care professional and four health professionals also shared their views on the quality of the care at home.

Requires improvement

Is the service safe?

Our findings

Most aspects of the service were safe but there were areas for improvement. For example, the management of recruitment. Some staff were recruited from an employment agency. The registered manager had requested the agency sent references for each staff member and provided a Disclosure and Barring Service (DBS) check but this had not consistently happened. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One person was shadowing shifts at the home until all of their documentation was in place. They had a DBS from a previous employer but information had not been sought from their previous care employer regarding their conduct. They were living at the home on a temporary basis. They had access to vulnerable people and therefore this was a risk. By the second day of the inspection, we were told the person had chosen to leave the service; the registered manager stated they would not use the employment agency again. The management team told us the reasons why some staff had gaps in their employment history, which a staff member confirmed. However, these explanations had not been recorded.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several visitors commented on staff turnover; the operations manager acknowledged three staff were leaving to develop their skills further. However, she explained some staff had previously left but then chosen to return indicating it was a good home to work in.

A health professional had expressed concern over the management of risk of pressure damage in August 2015. On this inspection, risks to this area of people's health were not consistently well monitored. For example, one person's risk of pressure damage was increasing according to records but this had not been identified in the reviews of their care plan. Staff said the person sometimes chose to sleep in a chair rather than their bed. However, there was no assessment to how this decision potentially could increase their risk of pressure damage. We also identified another person where improvement was needed to manage the risk of pressure damage. Staff confirmed people were referred to district nurses, when necessary, and understood the risks to people's health.

Care planning was not always responsive to increased risks for people's health and safety. For example, a person had left the building without staff being aware. One staff member commented the person had left the building on other occasions. They said staff had not been able to maintain visual checks that were introduced to monitor the person's whereabouts. We saw a risk assessment in the person's care plan file detailing how the person moved around the home to an extent staff did not always know where the person was. We saw the person about to enter another person's room without an invitation. The registered manager was with us and guided them away. On one occasion when the person left the home, a review took place promptly after the incident, but there were no changes to their care plan or risk assessment after the review.

Falls risk assessments were completed and audited. The management team had recognised that assessment tools did not always accurately reflect the risk to people's safety so they also considered the impact of infections and, where necessary, made referrals to the rehabilitation team. Actions had also been taken to remove equipment, such as bed rails, if they increased rather than reduced the risk to people. Body maps were usually completed when people had bruising or injuries to their body. The registered manager told us senior care workers followed up marks and injuries recorded on body maps, to see if they were healing, and filed the body map once the problem was resolved.

Most areas of the home were safe but the doors to two laundry rooms did not have a lock fitted and contained chemicals with the potential to harm people. This was brought to the management team's attention who confirmed locks would be fitted.

Safety measures had been taken to protect from the risk of burns from radiators and falls from windows. Equipment for moving people had been serviced to maintain safety standards. Checks had been completed for gas and electricity appliances. A fire risk assessment had been carried out within the last year and people had personal emergency evacuation plans in place, although one had not been updated to reflect a change for the person. Staff were clear where this information was held in the event of an emergency. The management team said they had gained the support of neighbours to assist in the event of an emergency evacuation.

Requires improvement

Is the service safe?

One visitor was very confident their relative was safe. The management team gave examples to show how they ensured the home ran safely. For example, the registered manager explained how a few staff had chosen to supplement their hours by working at other care homes. She described how she liaised with these other services to ensure that the staff were not working excessive hours so they could still work in a safe and effective manner.

The management team gave examples where they had assessed people as needing nursing care. They had requested assessments from the local authority to enable people to move to places where their complex physical health care needs could be met safely. A social care professional said they received timely referrals when people's needs had increased. Health professionals said referrals were made in a timely manner and advice was followed. The management team also explained how they reviewed requests for new admissions. This was to ensure an appropriate mix of people within the home; this had led to several people not moving to the home.

The management team said they had trialled various dependency tools to assess how many staff were needed. However, they explained they supplemented these tools by observing staff to judge if they were under pressure. For example, taking time to discuss with care staff if people had increased needs, which would impact on the number of staff needed. The management team explained how the care staff could be shared between the two sides of the home depending on level of need. Rotas showed staffing levels in the morning varied between six and eight care staff, in the afternoon this number reduced to between five and seven care staff, with four care staff at night. They were supported by the registered manager on weekdays, administration staff, catering and housekeeping staff. There was also an on-call system in case of emergencies or queries.

Several staff said they had no concerns about staffing levels, although they commented the level of support people needed could be variable. We noticed over two days that staff rarely sat with people to have a chat unless it was connected to a caring task, such as supporting a person with a meal. The management team said staff were encouraged to sit and eat with people, although this did not happen during our inspection. One person living at the home said "In my opinion they haven't got enough staff, they have no time to talk, they dash in and dash out".

Several other people said more staff were needed but did not give specific reasons for this opinion. One person said staff were "very attentive". A visitor said staff were "stretched" and "It's a shame staff don't have more time."

The deployment of care staff required improvement to ensure staff were present in communal areas. For example, there were periods of time when care staff were not monitoring what was happening in one of the lounge areas. During this time, we saw one person take another person's drink, drink it, and walk away with the cup. They did this again but this time they were observed by passing staff, who then replaced the other person's drink. The person's care plan included they took food from other people so they were to be monitored by care staff. There was also an incident form where their actions during a meal had upset another person living at the home leading to an altercation.

A person rang their bell to request support from staff with washing. Staff attended within five minutes, asking the person to wait "a few minutes". The person asked how long this would take and were told about 15 minutes. A staff member later visited briefly asking how the person was, with staff returning 30 minutes later to assist the person with their personal hygiene. A visitor said they were concerned because on three occasions their relative still had their lunch plate in front of them when they visited at 3pm. Lunch was served at approximately 12.45pm. Staff had told us this person ate slowly.

Two people indicated they were discouraged from using their call bell, with one person implying staff would take a long time to arrive. We encouraged them to ring the bell and staff came within five minutes, greeting the person politely as they entered the room. We visited another room and accidently set off a door alarm in an upstairs room, staff came quickly to respond to the alarm. A call bell log was kept, which the management team said they could review to monitor staff response times.

The home's 'customer satisfaction survey' in May 2015 did not directly ask relatives about staffing levels. Instead, it asked if staff were 'accessible and helpful'. The six respondents rated staff as 'excellent' or 'above average' in answer this to question. However, several people commented there were not enough trips out or staff to support people to access the garden. Staff said they did not currently have time to take people out. However, they supported people's families so they could take them out,

Requires improvement

Is the service safe?

which we saw, happening. Staff said the previous activities co-ordinator had offered to take people out. They said this would hopefully be addressed by the recruitment of a new staff member for this role.

We recommend that the provider should consider how they assess staffing levels to meet people's needs, including how to deploy care staff in communal areas of the home

Most rooms were clean and odour free, which helped support people's dignity. But two rooms needed further attention to address a malodour; the management team said they would ensure this was addressed by the housekeeping staff. Staff were seen adopting infection control good practice using the equipment available, such as gloves and aprons. Health professionals visiting the home commented improvements could be made to the general level of cleanliness. Several visitors also said areas of the home could be cleaner.

Medicines were administered safely. For example, the registered manager told us when people first moved to the home, staff obtained information on their current medicines from their GP. They checked this against any medicines people may have bought with them. This was good practice as it ensured staff had accurate information about people's current medicines. Staff demonstrated safe practice. For example, staff did not complete the medication administration record until the person had taken their medicines.

Staff observed people's behaviour and body language and if necessary checked with colleagues to assess when they might need pain relief. We saw there was written guidance for staff. This was to ensure the medicine was administered consistently, regardless of which staff were on duty.

Staff had a comprehensive understanding of safeguarding vulnerable people. For example, staff could describe different forms of abuse, including withholding food or medicines. They could describe possible signs of abuse such as a person's withdrawal, signs of fear on being approached. One staff member added "You have to know them", explaining that some people would not be able to tell staff they were being abused but a change in their body language or behaviour could alert staff. One staff member commented they were always asked in their supervision meetings if they had concerns about any of the people they supported. Staff knew who concerns should be reported to within and outside of the organisation.

Good

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 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. Further work was needed to check whether visitors had the legal power to make decisions on behalf of residents as this was not recorded.

One person who lacked capacity to be involved in the decision had recently moved to a new bedroom. Staff said the person had responded well to moving to a different area of the home, which had helped them become more settled. Staff clearly felt the decision was in the person's best interests. A social care professional said there had been other occasions when changes to people's bedrooms had been managed well. For example, meetings being held to ensure the change was in the person's best interest.

Staff demonstrated an understanding of the MCA in their discussions about people's ability to make decisions and how they should be involved in day to day decisions. Staff were reminded of the principles of the MCA and their role to ensure people were not unlawfully restrained in a team meeting. Staff practice showed they understood the principles of the MCA. Staff translated this theory into practice. For example, one person received their medicines covertly, crushed and concealed in a specific drink. Their records provided detailed instructions on how staff were to carry this out. There was a record of a mental capacity assessment and best interest decision in relation to the covert administration, to ensure the person's rights were upheld.

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. For example, one person living with dementia told us they were feeling "stroppy" and talked about being in prison; an application had been made to deprive them of their liberty. Staff went to reassure them after we shared our concern about their mood. Where people are deprived of a liberty, care homes should apply for a Deprivation of Liberty Safeguards (DoLS) authorisation. Applications had been made to the local authority for liberty DoLS authorisation.

The management team made sure the needs of people were met by staff with the right skills, experience, attitudes and behaviours. A health professional commented that overall staff did a good job and another said the senior staff were experienced and committed. A training schedule was in place, which showed staff were provided with a range of training, including moving and handling, infection control, food hygiene and fire training. Staff members who had changed their role within the home were provided with the training to enable them to undertake their new role. Staff confirmed supervision took place, although records showed this was not happening regularly. Staff meetings supplemented supervision and took place on a monthly basis. During these meetings, staff were updated on the training available and good practice was promoted, such as moving people safely or promoting choice.

Staff said they could ask advice from their colleagues or go to the registered manager if they had queries as she was approachable. They said one-to-one supervision sessions with more senior staff were useful if they were "struggling." One staff member gave an example of how they had changed their practice following guidance. This meant they now felt able to support an individual in the way the person preferred. The staff member described how their practice had changed to be more person centred.

Staff administering medicines underwent learning about medicines through a national **training** provider which specialized in the care sector. New staff had their practice observed three times to ensure they were competent to administer medicines unsupervised. They also had access to information on medicines such as patient information leaflets and a nationally recognised pharmaceutical reference book. Staff were proactive in seeking further information from the supplying pharmacist to expand their knowledge.

Staff told us about training to enhance their understanding of the needs of people living with dementia. They commented how this had influenced their practice. For example, one staff member described trying to interpret people's movement and body language when people were unable to verbally describe how they were feeling. Some staff described undertaking health and social care training, supported by external assessors, which they then shared with the other staff.

We saw many good examples of staff assisting people with day to day choices, such as what they would like to drink.

Good

Is the service effective?

Staff took time to explain choices to people and did not rush them. For example, a staff member gave a person a range of drink options. The person had difficulty comprehending the choices and appeared a little anxious about the decision. The staff member recognised this and supported them to look at the tray of drinks. This enabled the person to relax and make an informed choice as they understood what was being offered by seeing the drinks.

Staff checked with people how they wished to be supported but also knew when to change their approach which demonstrated their training and skills. One person became agitated after a meal requesting staff to support them to stand when normally according to their records and staff they stood independently. Staff encouraged them to stand and reassured them. The two staff members briefly withdrew and the person stood without assistance, which showed staff had made the right decision. They praised the person for moving independently.

We saw records of visits from health professionals in people's care records and information in staff communication books. The registered manager and staff recognised changes in people's health and made referrals in a timely manner. For example, following a person becoming ill on the first day of our inspection a referral had made to the speech and language team. Staff confirmed handovers took place at the beginning of shifts and communication books were in place to update staff on changes to people's health. Staff who were not involved in care were kept informed about changes to people's health needs. For example, staff working in the kitchen were made aware of this change in the person's health and changed the preparation of their food accordingly.

People's weights were monitored and staff were attentive during a lunchtime meal to help ensure people ate and drank adequately. They changed their approach for each individual. For example, subtly prompting a person to eat independently and attentively assisting another person who needed more support. People were regularly encouraged to drink and staff ensured people's drinks were replenished and were prepared to the people's individual taste. Staff described how the advice of health professionals was sought if people's health changed, such as their ability to swallow. Staff know what type of meal each person needed and a board in the kitchen contained information about risks to people's well-being, such as allergies.

Staff changed their approach to suit the individual's preferences. For example, at lunchtime a staff member chatted with people as they settled them at the tables and served drinks. When one person left some of their meal, staff asked if they would like something else, offering the alternative cooked meal. Another person left the table before dessert was served, the staff member advised them of this but the person still chose to leave. Later the staff member offered them a dessert again to ensure they did not miss out.

Most people commented favourably on the food. For example, "On the whole I like the food", "The food is very nice, oh yes and plenty of choice", "it is quite nice" and "Yes. I like the food." Two people commented the quality could be variable depending who was preparing the meal. The management team said a recent change in staffing had addressed this. An established cook supplemented the meals, which were prepared externally, with home-made custard, mash potatoes and roast potatoes. They also prepared a range of homemade cakes, which people praised. People told us there was enough to eat and staff were seen offering 'seconds'.

Good

Is the service caring?

Our findings

People said staff were kind and respectful in their approach. For example, "The staff are happy and talkative." People told us "They look after me", "They are very good", "The one who's in charge this morning is very nice", "I'm quite happy here" and "They seem all right." A visitor said "She gets all the attention she needs, I can slip in and liaise with the staff any time I want" and another commented "she gets lots of love, she's been well cared for." A visitor said staff had reached a compromise with their relative to assist them with personal care on their terms while still maintaining their hygiene and dignity. They said staff were "very friendly, good and helpful." Staff said this approach had been successful and had reassured the relative as they knew they cared and would listen to the person's point of view. The person was relaxed and at ease with staff.

Staff respected people's dignity by knocking on bedroom doors before entering but en-suite toilets did not have locks which had the potential to undermine people's privacy. Staff were respectful when they spoke about how they supported people living at the home. Staff told us how they promoted people's privacy and dignity. For example, they described keeping people's personal information private, by knocking before entering rooms and keeping people covered as much as possible during personal care. Health professionals told us staff respected people's dignity.

Staff guided people to help them find their way around the home and recognised when people were looking worried or anxious and supported them to find the toilet. A staff member told us they involved people in their own care by maintaining their independence where possible, such as enabling them to wash their own face. They also told us they gave explanations and sought people's agreement. They went on to say they were careful, if two staff were assisting a person they did not both speak to the person at once, as this could be very confusing to the person they supported. Over our two day inspection, we saw many examples by a range of staff maintaining people's dignity and acting in a considerate and caring manner.

People received care and support from staff who knew and understood their history, likes and preferences. For example, a staff member told us staff had to go along with what one person said or asked, which was detailed in the person's care plan. This was to avoid upsetting them, even though this did not always seem the best course of action. Staff gave the example of the person asking to be sat upright while asking for a pillow to be placed where it would prevent this from happening. The staff member provided the pillow as requested but also then placed a second pillow that supported the person to be upright, without drawing attention to this. This example showed how staff used their knowledge of individuals and their skills to meet both their needs and their wishes.

A staff member said they "wouldn't hesitate to whistle blow, because these people are here to be cared for. You see what they've done with their lives!" and went on to express admiration for individuals' achievements. Staff were heard talking to people about their interests and their past as they supported them. Staff clearly knew people as individuals, describing or providing person-centred support to help people take their medicines. For example, knowing one person preferred sweet things so staff requested the GP to prescribe, where possible, liquid preparations for them, which were sweetened. Health professionals commented staff knew the people they cared for well; this also included the management team.

The management team demonstrated their commitment to providing a caring and compassionate staff team. For example, minutes from a staff meeting showed they had discussed the key findings from recent Dementia Care Matters training. They explored the power of language with the staff team to promote a respectful environment and the need to focus on the positive and the strengths of the people living at the home.

Staff were polite and patient when supporting people, they showed a caring approach when they adapted their communication to meet people's individual needs. For example, at lunchtime, one person complained of the cold when an external door near them was opened. Staff heard the comment and responded promptly, asking if the person wanted help. The person was unclear what help was being offered so the staff member carefully rephrased the question and then went to get some warmer clothing. This example showed staff were caring and took time to involve people. We saw many examples of this type of good practice during our inspection. One staff member said all their colleagues were "very attentive, kind, helpful, professional."

Several visitors praised the work of staff because of their attentive approach and kindness. Their only concern was a

Good

Is the service caring?

few staff, who did not have English as a first language, did not have a wide vocabulary. This meant they occasionally struggled to re-phrase sentences to help people understand. We observed this during the inspection. This issue was also commented on by health professionals.

One staff member said they had a particular interest in providing care for people at the end of their life and they were positive about planned external training to help them develop their skills further. Staff working in the kitchen said they liaised with this particular staff member about meeting people's changing needs and to cater for their preferences around particular food at the end of their life.

Requires improvement

Is the service responsive?

Our findings

The management team responded to complaints when they were made aware of them and they were investigated and overseen by the general manager and the provider in order to identify themes. Complaints records showed they had taken to time to work with people, their families and other health and social care professionals to try and resolve people's concerns and complaints. The actions of the management team demonstrated a commitment to reassure people and an understanding of the emotional pressures families were under. However, there was not an active approach to ensure people knew how to complain and who to complain to. We were told complaints information was in people's individual rooms. In one bedroom, there was complaints information which was out of date, while in five other bedrooms there was no information.

There was a service user guide but the complaints information was limited with no timescales; a relative said they had not been provided with a copy and another person was unsure if they had seen a copy. Another visitor said staff did not wear names badges and there was no information about the names of staff on display, which potentially could make it difficult to complain about individuals.

Care staff told us they had been advised to direct a person who was complaining to senior staff, which was confirmed by minutes from a staff meeting. The management team said they hoped this would promote a more consistent professional response and ensure the complaint was accurately logged. Discussion took place about how concerns rather than formal complaints are captured centrally by the management team. Currently there was not a system to identify if there were themes and patterns emerging, such as malodour.

Staff told us they would report to senior staff, if an individual appeared unhappy but was not able to verbally express the problem. This would then be discussed between staff to try to find the cause, being mindful there could be a medical reason, such as a urine infection. One staff member described a very recent complaint. Staff were busy and had not assisted a person to be ready in time to be taken out. This was the only occasion the staff member knew this had happened. The next week staff ensured the person was ready on time and apologised. The staff member told us "What does an apology cost?" People said "I'm quite happy here" and "I've nothing to complain about, it makes a big difference if you can talk to people."

We focussed on the care needs for five people. People's care needs had been assessed based on a range of information and each person had a care plan. However, care planning did not provide guidance to staff about how to respond to people living with dementia who became anxious and frustrated. A theme through one person's care records was they could 'become aggressive and agitated at times'. There was no guidance to staff to encourage a consistent person-centred approach to diffuse these situations or to know what might trigger the aggression. However, staff said there was rarely aggression by this person The provider told us 'Although there are not behavioural care plans in use, all staff had 'behaviour that challenges' training in order to manage a range of behaviours that are not predictable.'

One person said they now felt isolated in their first floor room. This was because they struggled with accessing the ground floor of the building as there was no passenger lift and they were reliant on a stair lift. They said "It's such a job getting downstairs I stay in my room the steps outside my room are too high." To access the stair lift they had to negotiate steps that were higher than is recommended and they told us this now resulted in them staying in their room as their health had deteriorated. The provider confirmed alternative rooms had been offered to the person and the person was supported to access communal areas. We shared their difficulties with the local authority commissioning their service. Other people had been moved to different rooms in recognition of their changing needs.

Staff practice showed they usually observed changes in people's well-being and reported on them appropriately. For example, there was a medical emergency during our visit. Staff had observed a change in someone's condition. Care staff reported this to senior staff, who promptly contacted the person's GP and family. Staff liaised with the person's family about what support the person should receive, as this was different to what had already been discussed and agreed.

Staff told us about one person whose condition they felt was deteriorating. They pointed out the person had needed help to eat that day and how their ability to move had

Requires improvement

Is the service responsive?

changed. They described how, when the person had been unable to manage ordinary cutlery, staff provided a pastry fork instead, which was lighter for them to use. Daily care records also reflected these changes in recent weeks. Senior staff told us the GP had been asked to review the person because of some of these changes.

The management team said they kept a stock of equipment across the three homes owned by the provider so they could respond quickly to people's changing health needs. An example of this was changing the mattress of a person who had become ill during our inspection to one that reduced their risk of pressure damage. Staff were being trained across the three homes in assessing people's moving and handling needs so they could respond to a change in people's care needs.

Equipment, such as moving and handling belts were available in people's room. However, this information was not always documented in their care records, which could potentially lead to an inconsistent approach by staff. The provider stated the staff were trained to be responsive to falls, trips and unpredictable behaviour and therefore ensured a range of moving and handling equipment was available. A social care professional said they received appropriate referrals from the management team. These referrals were for people who either needed nursing care at an alternative setting or needed their care reviewed because their care needs had increased. For example, a person was funded to move to a larger more accessible room after their physical needs had increased and equipment was needed to move them.

A staff member said "The girls are really good at passing on snippets of information, such as 'If you do this, that will happen'", explaining staff shared information when they had found a more successful way of supporting people in some way. For example, when a person moved to another part of the home, the person was assisted to sit at a dining table for their meals, which was not their usual routine. They had settled at the table and ate better than they had before. The staff member also told us staff liaised with each other throughout the day, so learnt about any changes to ensure people got the support they needed. We saw staff planning with each other how they were going to support people, such as in the morning, when people were waiting to be assisted up for the day, and at mealtimes. Health professionals commented particular staff members were up to date about people's health needs; one said the management team were knowledgeable but felt improvements were needed to ensure all care staff were updated. The management team had introduced handovers sheets to encourage better communication between staff.

There had been an activities co-ordinator role at the home until the end of September 2015 and newsletters showed how external entertainers had visited the home, including a visit from the local donkey sanctuary, as well as craft activities. One person commented "I've had one or two trips; I have been down to the sea but not had a swim yet." One visitor said "There's not enough going on" and "People are just sitting around in chairs vegetating." They told us the TV was always on, with no-one watching it, when they visited. Staff told us they made watching 'Strictly come Dancing' a social event by encouraging people to join together to watch it and give their views.

The management team said a new staff member had been recruited for the activities role but they had not been able to take up the position and so the role was being advertised again. Care staff started an impromptu singing session and a quiz on names, which people responded well to. However during our visit some people told us they were bored and some visitors expressed concern there was not enough stimulation for their relatives. People's care records did not demonstrate how staff supported people to engage in activities. Care staff said they tried to fit in activities when there was time but acknowledged they did not usually record this happening.

Requires improvement

Is the service well-led?

Our findings

Improvements were needed to some aspects of quality assurance systems within the home. The provider said there were policies and recruitment checklists in place linked to recruitment. Recruitment was checked annually. They explained that 'there has not been any indicators on the audit that recruitment process was failing, however now it has been identified as with all other areas of quality assurance it will be proportionate and appropriately monitored'.

The management team said there were no rooms with a malodour. They told us there housekeeping audits for malodour but several rooms needed further attention by housekeeping staff to address on-going unpleasant smells. Medicine audits did not clearly show when people's medicines had been reviewed and had not identified when medicines had expired for two people. A medicines audit had not highlighted how there was not a consistent system to ensure people's pain relief patches were changed in a timely manner.

Guidance to staff connected to pressure care and supporting people with anxieties relating to their personal care needed to be improved, including the quality of reviews. The provider told us 'Care planning has just come out of a programme of improvement, the care planning was produced from collaboratively working with the safeguarding nurses ... the care plans are reviewed and retyped regularly in order to avoid scribbles on them which is why they seem that updates have not been carried out. Care plans are routinely reviewed by all members and disciplines of the team and outside professionals.'

Maintenance of the building and equipment took place, which included safety checks and servicing contracts for fire safety equipment, gas, electrics and lifting equipment. There were two areas where further work was needed. These were highlighted to the provider, who responded quickly to confirm the work was now in progress. Audits of the building had not identified laundry doors were not lockable, which had the potential to put people at risk of harm; the management team said this would be addressed.

There was a central audit collated by the management team, which included the registered manager, the operations manager and the provider. Each had different quality assurance roles assigned to them and they could check on each other's timescales for completion dates. The registered manager submitted information on the progress of the task allocated to them and meetings took place for the management team to update one another. For example, the operations manager reviewed the weights of people and identified any patterns or trends that needed to be monitored. Senior staff also told us food and fluid charts were audited weekly to monitor people's intake as well as to check they were being completed. Other quality assurance checks included kitchen and food delivery audits, observations and hands on involvement by the management team.

The management team provided us with examples of how they had improved the service since our last inspection. They had enhanced their admissions process to ensure all relevant information was gathered about an individual before they moved to the home. For example, one person required specific equipment before their admission. Improvements included the creation of a virtual tour to enable people and their families to look at the home to help decide if it was the right place for them before coming to visit. The management team shared a number of examples where they had worked with other professionals to ensure people received the service they were entitled to, such as local authority reviews.

Since the last inspection, there has been investment in the environment including new furniture and equipment. Front doors had been added to people's rooms to help them orientate themselves and work had taken place to provide clear dining areas to help focus people on their meals. The management team had also held training sessions to ensure staff were up to date with new legislation and regulation, including training on the Duty of Candour.

Surveys were sent out to gain visitors views on the quality of the service, although the response rate in May 2015 was low with seven surveys returned. The management team said 'We try to gather learning and implement improvement with all comments, for instance we had feedback from a relative about the side gate and gardens, we enlisted the support of a team of gardeners for three days and also had a new side gate made and installed.' There had not been a recent relatives' meeting, although the provider information return stated these happened regularly. Two visitors commented they would have liked

Requires improvement

Is the service well-led?

more information about the service. The management discussed how they could ensure people were routinely provided with information about the service, which would then be logged to show how people were kept informed.

Staff felt they would be listened to if they whistle blew about abuse or poor practice. One staff member said they had reported practice issues to the management team, which they saw as part of their role, which had been followed up and addressed. Staff had reported concerns about poor practice, which had been addressed by the management team. This included a letter to all staff reminding them of their responsibility to provide safe care. Staff were asked about safeguarding concerns in their supervision. Staff told us the management team were approachable. Spot checks had been completed by the registered manager at night to ensure staff were working in an appropriate manner.

Staff told us they felt well supported, with the seniors, registered manager and operations manager available to them for support. One commented the registered manager was "wonderful", explaining she had worked 'on the floor' before her promotion so understood the home well and this was beneficial to staff. Another staff member said the senior carers were able to give appropriate advice about individuals' care. Staff felt listened to, with their suggestions or concerns followed up. For example, in one team meeting, staff highlighted there were not enough moving and handling belts, these were then quickly purchased by the registered manager.

Staff told us the home was well-led and the staff were organised well. We asked staff if there was anything else they wished to tell us, one said "I love working here!" Several others told us they enjoyed everything about their job and that the staff got on very well together. We asked the management team what their greatest achievement had been at the service since the last inspection. Their comments reflected feedback from staff which included improving care and staff morale, which they felt had resulted in improved staff dedication and attitude.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures did not operate effectively to ensure a consistent approach.**