ADL Plc

Allambie Court

Inspection report

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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**

Summary of findings

Overall summary

The service was last inspected in October 2013. It was found to be compliant in all outcomes we looked at. This inspection took place on 23 March 2016 and was unannounced.

Allambie Court is registered to provide accommodation with nursing and personal care for up to 30 older people who are living with dementia. At the time of our inspection visit there were 26 people living in the home.

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

People were comfortable with the staff who supported them and relatives were confident people were safe living in the home. Staff received training in how to safeguard people from abuse and understood what action they should take in order to protect people from harm. Risks to people's safety were assessed, but risk assessments were not always updated in response to incidents or changes in need. The provider's checks had not identified this.

People were supported with their medicines by staff who were trained and assessed as competent to give medicines safely. Medicines were given in a timely way but in some cases were not given as prescribed. Checks designed to ensure medicines were administered safely had not identified this.

There were enough staff to meet people's basic care needs. However, it was difficult for staff to find time to interact with people outside of completing care tasks. People were not routinely engaged in activity which had been identified as being meaningful to them. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff told us they were not able to work until these checks had been completed.

The provider ensured staff had information on the level of support people needed with decision-making so people were protected. Staff and the registered manager had a good understanding of the Mental Capacity Act, and the need to seek informed consent from people before delivering care and support. Where restrictions on people's liberty were in place, legal processes had been followed to ensure they were in people's 'best interests', and applications for legal authorisation had been sent to the relevant authorities.

Staff were respectful and treated people with dignity and respect. People were supported to make choices about their day to day lives.

People had access to health professionals when needed and we saw the care and support provided in the home was in line with what had been recommended.

Relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. Staff told us the management team were approachable and responsive to their ideas and suggestions. There were systems in place to monitor the quality of the support provided in the home. However, these systems had not always worked as intended as gaps and inconsistencies in the quality of care people received had not always been identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's needs had been assessed and risks to their safety were identified. However, risk assessments had not always been updated to reflect changes in people's needs so the provider could be assured people were always supported safely. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. Medicines were administered by staff who were competent to do so, but were not always given as prescribed.

Is the service effective?

Good

The service was effective.

People's rights were protected. Where people lacked the capacity to make all of their own decisions, the provider protected people's rights under the Mental Capacity Act (MCA) by assessing people's capacity and the support they needed with decision-making. Staff sought consent from people about how their needs should be met. People were supported by staff that were competent and trained to meet their needs effectively. People received timely support from health care professionals to assist them in maintaining their health.

Is the service caring?

Good

The service was caring.

People were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs. Staff showed respect for people's privacy and talked with them in ways they could understand.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning and review was not robust and in some cases there was no evidence that this had happened. This meant people were not always supported in ways that were focussed on

them. People did not have the opportunity to engage in activities which took note of their personal interests, likes or dislikes. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People felt able to approach the management team and were listened to when they did. Staff felt supported in their roles which meant there was a culture of free and open communication between staff and the registered manager.
Systems designed to check the quality and safety of the service provided were not being used and were not effective. This meant it was difficult for the service to improve as a result. The registered manager found it difficult to find time to fulfil their role as registered manager while they were also on duty as one of the nursing staff. The provider had acknowledged this and recruitment was therefore underway for a nurse.

Allambie Court

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.

The inspection visit took place on 23 March 2016 and was unannounced. The visit was conducted by an inspector and a nurse specialist advisor.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection visit. We found it accurately reflected what we saw during our visit.

During our inspection visit, we spoke with three people who lived in the home. The people we spoke with were not able to converse with us fully, and so we also spent time observing interactions between people and staff. We also spoke with three relatives. We spoke with the registered manager, a member of nursing staff, and four care staff.

We reviewed six people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us, "Oh, I feel safe alright." People told us if there was anything they were worried about they would feel happy to talk to staff about it. One person said, "If I was worried about anything, I would talk to the manager." We spent time observing the interactions between the people living in the home and the staff supporting them. We saw people were relaxed and comfortable around staff and responded positively when staff approached them. Relatives told us they thought people were safe and well cared for. One relative told us, "[Name] was forever falling at the last place. Here, they seem to have sorted that. [Name] has a falls mat in place so staff know if [name] has fallen."

The provider protected people from the risk of harm and abuse. Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. Staff were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. One staff member told us, "I would go straight to the manager if I had any concerns."

There were policies and procedures for staff to follow should they be concerned that abuse had happened. The registered manager had made safeguarding referrals to the Local Authority, and notified the CQC when referrals had been made. The registered manager kept written records of safeguarding referrals they had made so they could keep track of them and identify the outcomes of any investigations. However, we did not see any evidence that the registered manager had used the outcomes to encourage learning.

The provider's recruitment process ensured risks to people's safety were minimised, and that staff with the right skills, knowledge and values were brought in to work at the home. Staff told us they had to wait for checks and references to come through before they started working in the home. Records showed the registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about potential new staff. The DBS is a national agency that keeps records of criminal convictions.

Risks relating to people's care needs had been identified and assessed according to their individual needs and abilities. Action plans were written with guidance for staff on how to manage those risks. However, care records showed these had not always been reviewed after incidents which might have increased risks to people's health and safety. For example, one person had had their risk of falling assessed which had been last reviewed on 21 February 2016. Records showed that between 28 February and 20 March 2016, the person had fallen six times. Their safety care plan had not been updated and there was no evidence that observations of the person had been increased post falls even when one fall had resulted in a head trauma. Another person had moved into the home on 8 February 2016. Their risk assessment had still not been completed so the provider could be assured any risks associated with the person's health and wellbeing had been identified and managed.

Some people were at risk of skin breakdown. Care records showed that where people were at risk of this, they had been assessed and risk management plans had been put together. Some people had been

assessed as needing to be re-positioned every two hours to reduce pressure on one area of the skin. Charts recording position changes were not always kept up to date, and there were some gaps in recordings. This meant it was difficult for staff to know whether or not the person had been turned as required to reduce the identified risks.

We observed people in communal areas of the home. Where it had been identified people were at risk of falling, staff knew about the risks and were on hand to provide guidance and support. For example, one person who had been identified as being at risk attempted to get up from their chair on several occasions over lunch time. Staff talked calmly with the person and walked with them rather than trying to get them to sit straight back down. One member of staff walked with the person and returned to the lounge area shortly after. This kept the person safe without causing distress which could have escalated their anxieties.

Other risks, such as those linked to the premises, or activities that took place at the service, were assessed and actions agreed to minimise the risks. This helped to ensure people were safe in their environment. However, it was not possible to assess how effectively routine safety checks such as gas and electrical item checks were completed. The registered manager told us these checks were held in a 'maintenance folder' but this could not be located on the day of our inspection visit. We saw a maintenance worker attending to minor repairs in the home, and staff told us if they reported issues relating to the maintenance and upkeep of the building, these were attended to.

Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. There was a kit bag at the fire board which contained essential emergency equipment which might be needed in the event of a fire evacuation. However, people did not have personal fire evacuation plans, so staff followed a general fire evacuation procedure, which was not responsive to people's different mobility needs. We spoke with the registered manager who agreed this needed review to ensure people's safety in the event of a fire.

Some relatives told us they thought there were not enough staff. One relative told us, "I like the staff but I think they are a bit understaffed at times. I have visited a few times when altercations have happened between people. I don't think there are enough staff." Staff told us it could be difficult at times. One member of staff told us, "We don't get time to read the care plans." When asked if there were enough staff, one staff member said, "Sometimes yes, sometimes no. The manager tries to get bank staff in if we are short." We spent time observing how people's needs were met in communal areas of the home. We saw staff supporting people to move from communal areas to their rooms or bathrooms for personal care, and we saw those people return to communal areas shortly afterwards. We also saw people were reassured by staff if they were anxious or unsettled. When people rang call bells in their rooms for support, staff attended to them in time to be able to support them. However, we did not see staff sat and talked with people or engaged them in one to one activities. Whilst there were enough staff to keep people safe, the main interaction with people was focussed on offering support or completing care tasks. One staff member told us, "Care staff don't get time to do cooking or anything like that with people."

The registered manager told us they used a dependency tool to establish how many staff were needed to meet people's care needs. The registered manager told us staffing was flexible, and "depends on what is happening on the day. We can bring extra in if we need to." The registered manager used agency staff to ensure there was adequate nursing cover. We talked with the manager about our observations that interactions between people and staff had been task led. They told us they thought staff needed more in-depth training on how to use their day to day interactions with people to stimulate them.

Medicines were stored safely and securely. Where medicines needed to be refrigerated, records showed the

temperature of the fridge was regularly checked and was within acceptable ranges. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely, and measures were taken to ensure they were properly recorded. Medicines were administered by nursing staff, who had their competency to do so assessed by the registered manager when they started. Thereafter, competence was checked on an annual basis, and records described how any identified issues during the checks had been dealt with. Staff who administered medicines had access to detailed and up to date guidance on the safe administration of medicines, along with the provider's policy and guidance.

Where people took medicines on an 'as required' (PRN) basis, plans were in place for staff to follow so that safe dosages of medicines were not exceeded and people were not given medicines where they might not be needed. These plans focussed on supporting people so that they did not need PRN medicines. Some people were given 'covert' medicines, which is medicine disguised, for example in food. Records showed that discussions had taken place with medical and other professionals to determine that the person did not have capacity to make a decision around medicines, and ensured this was done in their 'best interests'. Pharmacists had also been consulted to ensure the suitability of medicines to be given covertly.

Medicines were not always administered as prescribed. There was a folder containing the medicine administration (MAR) charts on each floor of the home. The folder held information about what medicines people were prescribed, as well as general guidance on good practice in relation to medicine administration. We observed medicine being administered to people living in the home and saw this was done safely, was unhurried and people were communicated with throughout. MAR charts were completed accurately and medicines had been signed for. However, four people were prescribed Lansoprazole. To be effective this medication should be given 30-60 minutes before food and this was clearly printed by the dispensing pharmacy on the MAR chart. This administration instruction was not being followed by the staff. This medicine had been given at the same time as other medicines and there was no system to alert staff as to what time food could then be taken. This was brought to the attention of the nurse in charge who confirmed they would ensure procedures were put in place so the medicine was given as prescribed. Four people received pain relief by a patch. A government Drug safety update was issued in 2010 due to the number of medication errors involving this medicine. The most frequently reported causes were lack of patch removal, application of more than one patch and application to the same area for several weeks. There was no chart for staff to record the site and removal of the old patch and the site of the replacement patch, and we did not see evidence that this was recorded elsewhere in people's care records. This meant there was risk that people might be given more medication than they had been prescribed. Again, this was brought to the attention of the nurse in charge for action.

Records showed checks of medicines had been done by the registered manager, the last of these being 7 October 2015. This had not picked up on the issues we identified during our inspection visit.

Good

Is the service effective?

Our findings

Most people we spoke with were unable to give an opinion on whether or not staff were well trained and knew how to support them. However, one person told us, "One lady is brilliant." When asked if they thought the staff were well trained, one relative told us, "You can tell they are from the way they speak to people. The way they comfort them. [Name] can be hostile, but she is very comfortable with the staff due to how they talk to her."

Staff told us they had an induction when they started working in the home. This included training to help them ensure they were supporting people safely including health and safety; moving and handling and safeguarding. They told us they also shadowed experienced staff. The provider encouraged new staff to obtain further qualifications associated with their role. Some new staff had accepted the opportunity to undertake a Level 3 Diploma in health and social care. One staff member told us, "Through doing the NVQ, I am learning things I didn't already know." Staff told us they felt well supported when they started working at the home.

Staff told us they were well trained and knew how to support people effectively. They were satisfied with the range of training available to them. We saw staff helping people to transfer from one chair to another. They used a hoist where people had been assessed as needing this to support them. They did this safely and effectively, and seemed to be putting their training into practice. The home supported older people, primarily those living with dementia. One staff member told us about some training they had done on caring for peple with dementia. They said, "I never knew how to respond when people talked about deceased relatives as if they were still alive. The training clarified for me that you have to go into their reality." The registered manager acknowledged few of the staff had received specialist dementia training, although new starters had attended a short dementia awareness session. The registered manager told us they had been looking at training provided by Age UK, which they hoped would help staff turn day to day contacts with people with dementia into meaningful interactions.

A training record was held by the registered manager of the home, which outlined training each member of staff had undertaken and when. The provider had guidance in place which outlined what training staff should complete depending on their role. The registered manager told us they ensured this guidance was followed, and also monitored what other training staff needed. They told us this was in response to the changing needs of people being supported, as well as discussions with staff and day to day observations of their practice by the registered manager and senior carers.

Staff told us they had regular opportunities to talk with senior staff if they needed to. They told us the senior carers observed their practice on a regular basis and would frequently talk to them about how they might do things differently. Staff also had opportunities for formal supervision meetings. The provider had a "Supervision" policy, which stated staff should have a supervision meeting every six months. Records showed this had happened. In addition to this, staff also attended group supervision meetings. For example, staff had attended a group supervision meeting recently to talk about the correct use of slings for people who needed to be hoisted when transferring from, for example, a bed to their chair.

Staff told us there were handover meetings twice daily, once in the morning, and again in the evening. They told us this helped them to understand what had happened prior to them being on shift which enabled them to know how to respond to people so they could provide effective care on any given day.

The provider ensured nursing staff working in the home maintained their knowledge, skills and values. Records showed the registered manager conducted annual checks of nursing staff to ensure they complied with the requirements of the Nursing and Midwifery Council (NMC) to retain their professional registration. The nurse on duty at the time of our inspection visit was very responsive to care staff, helping them to resolve issues they were having with people's care. They were able to use their knowledge and expertise to give advice and guidance, and to ensure care staff took steps to support people to maintain their health and well-being.

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

Staff asked for people's consent before supporting them. We observed how staff approached people and explained what they were about to do. There was clear communication, and people were asked their opinions about how they wanted to be supported.

The registered manager had an understanding of the legislation in relation to the Deprivation of Liberty safeguards (DoLS). Where restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation. Two people had a DoLS authorisation in place and two others had a DoLs application in progress. Care records showed people's capacity to make particular decisions had been assessed. However, they did not include detailed information on how any identified restrictions were to be managed and kept under review.

The registered manager and staff understood their responsibilities to involve other people in helping to decide whether or not care and treatment for people who did not have capacity was in their best interests. One relative showed us a leaflet they had been given by the registered manager on a previous visit. It was an 'easy read' leaflet which explained the MCA and DoLS. They said the registered manager had told them, "It is because [name] is not able to make a decision about living here."

Risks to people's nutrition and hydration were minimised. People with specific needs and risks in relation to their diet had a nutritional assessment and care plans were in place detailing actions required. Care records showed one resident had lost weight. They had been referred to a dietician and their weight had stabilised. Another had been referred for a speech and language therapist (SALT) assessment following a choking incident. Care records showed the GP had recently been involved in reviewing people's medicines. Some people had been taken off medicines which were used to help manage mood, which indicated staff had been successful at helping people to manage this in other ways. Records also showed a range of other health professionals had been consulted on people's care.

Food and fluid charts were completed to ensure people at risk, were eating and drinking enough. However,

there were some gaps in these records and they were not always dated so it was difficult to establish if people had enough to eat and drink to maintain their health. Information on the food and fluid charts was not always being monitored to ensure risks associated with people's nutritional needs were being managed. One person we spoke with spent most of the day in their room. There was an empty plastic cup and bottle of water left on a table next to the person, but they were not able to reach it. We spoke with a member of staff about this. They said this was because the person tended to spill water if they tried to pour a drink for themselves.

We spoke with the chef about how food was chosen for people. They told us menus were determined by the provider every four weeks, and ingredients needed to prepare the food were delivered to the home regularly. They told us, "Most people are not able to tell us what they want, so if people don't seem to want what is on offer we try alternatives. Sometimes if someone is not hungry and does not eat, we will cover their meal, put it in the fridge and offer it to them again later." There was a board on display in the kitchen which included information on who had a special diet, for example, a softened or pureed diet. The chef told us if someone's dietary needs changed, the registered manager let them know and they would ensure the information board was updated.

Over lunch time, we saw people were assisted to eat at a comfortable pace, with staff communicating with people throughout. People were offered a verbal choice of what they wanted to eat but did not always appear to understand the options available to them. Where this was the case, staff did not offer a visual choice. One person who was unable to express a preference was given a little of both of the main options on the same plate. There were photographs on display in the dining lounge, which the chef told us changed when the menu changed. However, we did not see staff used these photographs over lunch to help people choose what they wanted to eat.
People had a choice of drinks with their meal, and were encouraged by staff to drink while they were eating.

Some people sat at a table to eat, some sat in easy chairs. Some people who ate in easy chairs wore large aprons which covered them down to their knees. They did not have overlap tables to put their food on and ate their food off their lap. Care records showed these people needed specialised equipment such as plates and cutlery so they could continue to eat independently. Whilst we saw the equipment in place, their ability to eat independently was not assisted by having to eat their meals off plates balanced on their laps. We discussed this with the registered manager who advised this should not be happening. They acknowledged that when using specialised equipment for eating, it would be preferable for people to have their meals off a table. They also acknowledged that this would also help to maintain people's dignity.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and treated them with respect. One person told us, "They [care staff] are pretty good. I enjoy living here. The girls are alright." We saw people interacting on a one to one basis with staff. One person was being assisted to move from wheelchair to an easy chair. The person said, "I am sorry to be a nuisance." Staff replied, "Not at all, you are fine." The person smiled and seemed reassured. Staff communicated with the residents effectively. They used different ways of enhancing their communication by touch, they ensured they were at eye level with those people who were seated, and altered the tone of their voice appropriately. One staff member was particularly good at interacting with people, and people responded positively to them. They were patient and kind and repeated information each time someone asked them as if it was the first time they had asked the question.

Relatives felt there was a caring, family-type atmosphere which helped people to feel cared for and valued. One relative told us, "The care here is unrivalled. I have never had one occasion to doubt their efficiency or their compassion." Another relative told us, "They [staff] are ever so nice and ever so caring. They talk to him [relative] nicely. In fact that is why we chose this place. We liked the way they spoke to people."

The registered manager had tried to ensure people's environment was comfortable and personal to them. The registered manager told us the home previously had shared rooms, but a decision was taken not to have any shared in order to support people's dignity and privacy. One relative told us how their relative had been supported to move to a new room which would better meet their needs. They told us the registered manager had been focussed on how the person would feel about moving. The relative told us the registered manager had asked, "Do you think [name] would like this room better?"
Staff supported people in ways that helped to maintain people's dignity and privacy. Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. We heard and observed staff seeking consent to interventions where people required support with personal care. Staff were also observed and heard to knock on bedroom doors and identified themselves on entering the room.

Staff encouraged people to be as independent as possible. Staff supported people in ways that made it possible for them to do things for themselves. While eating for example, staff encouraged people to hold their own cutlery. Relatives agreed. One told us, "They try and get [name] standing up. They do everything they can." We spoke with one person in their room who could not move independently. They said, "Carers come and take me out of my room as I can't move." Staff had ensured the person's alarm call bell was within reach and had draped it over the side of the chair they were sat in.

People were supported to maintain relationships with family and friends. Relatives told us there were no restrictions on when they could visit or how long they could stay for. On the day of our inspection visit, a number of relatives were visiting people, and we saw they were comfortable with staff and were made to feel welcome.

We saw people's personal details and records were held securely at the home. Records were filed

in locked cabinets and locked storage facilities, so only authorised staff were able to access personal and sensitive information.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they had been involved in reviewing people's care plans where people were unable to do this themselves. Relatives told us they thought care was provided according to people's likes, dislikes and preferences and staff had information they could use to ensure care was delivered in the way people preferred. People's care plans were written from the person's point of view, but they were often task focussed, and did not include information on how the day to day care people needed should promote their well-being. Daily notes staff completed for people were also task focussed, and did not show that daily interactions with staff, when helping with personal care for example, were used to engage people living with dementia. We saw interactions between people and staff tended to happen quickly when tasks needed to be completed, and we did not often see staff using information about people's likes, preferences, hobbies and interests to inform their discussions with them. Care plan reviews were often out of date and, where they had been reviewed, records did not evidence how this had been done or what had changed as a result and why. We spoke with the registered manager about this, who agreed care plan reviews needed to be undertaken more regularly to ensure staff had information they could use to meet people's changing needs.

People's care records did not always contain information about any hobbies or interests they might want to maintain. Neither did they always contain information on what activities people had been found to enjoy or respond well to. Care records contained two documents; "This is me" and "life style pattern and interests". Neither of these documents had been completed in the care records we looked at.

We did not see any activity taking place. Interactions with people were task focussed and, whilst staff engaged and interacted well with people, they did not involve them in activity which might have stimulated them. One member of staff spent much of the day while we were there sorting through books and other items for a raffle sale. We did not see people being encouraged to get involved with this. We discussed this with the registered manager who agreed this might have helped people feel occupied.

The registered manager told us the home had 16 hours of dedicated activity time per week and there was a weekly activity programme displayed on the wall. However, activities timetabled for the day of our visit did not go ahead as planned, and people did not seem to know what activities were on offer. We asked one person what was happening in the home that afternoon. They replied, "I couldn't tell you."

The registered manager showed us a "Tea Room" on the ground floor of the home, which had been opened in January 2016. This room had been decorated to look like a tea room, and in one corner there was a bar area. Whilst we saw people were sitting in this room, there was no attempt made to engage people with their surroundings or to us the environment to stimulate people. Whilst we did not see staff using day to day opportunities to engage people living with dementia, some staff told us they had received training which gave them the knowledge to do so. One staff member told us, "No matter what people talk about, we listen, talk to them, hear what they are trying to say. It is all about communication."

Relatives told us staff supported people according to their needs and wishes and responded effectively as their needs and abilities changed. They also told us they were involved in helping staff get to know people

better. One relative told us, "There is a whole resume on file of [name's] background."

DNACPR (Do not attempt cardiopulmonary resuscitation) forms we saw, varied in how well they documented how staff had responded to the wishes of people and their relatives as their health needs changed. There was clear documentation on one DNACPR form about discussions with the next of kin of someone who did not have capacity in this area. The next of kin did not agree with the DNARCPR, and the form fully recorded the reasons for this and how it had been determined that the next of kin was acting in the person's best interests. In order to manage this, a "saying goodbye to me" form was completed with the next of kin, which outlined their wishes and preferences and what they thought the person themselves would have wanted. However, another DNACPR form we looked at stated "discussed with son", but it did not evidence that full discussions had taken place and did not document how the decision not to resuscitate had been made.

Staff responded effectively to people's needs as they changed. For example, it was noted that there was low prescribing of medicines often given to people living with dementia, to help manage behaviours that might be challenging. Care records showed that use of these medicines had been reviewed by the GP and stopped in response to changes in people's health and care needs. The registered manager told us they worked well with the GP to ensure people did not take medicines if their health could be maintained in other ways. Staff were observed to respond well to people when they became agitated or anxious, so people were less likely to need medicines to assist with this.

The registered manager told us the home had 16 hours of dedicated activity time per week and Everyone we spoke with told us they were satisfied with the service and had no reason to make a formal complaint. One relative told us, "I am always answered and reassured if I ask a question or have a concern. But there have been very few." The provider's complaints policy was accessible to people which informed them how to make a complaint and how to pursue it if they were not satisfied with their response. Records showed that complaints received within the last 12 months had been resolved to people's satisfaction.

The service also kept a record of the compliments it had received. One compliment received in February 2016 said, "We would like to thank all the people at the home who made my mother's stay such a happy one."

Requires Improvement

Is the service well-led?

Our findings

People were positive about the registered manager. One person said, "The manager is very good." Relatives and staff told us the registered manager was effective in their role, approachable and responsive if they had any issues. One relative told us, "They sorted out a situation I had with one of the other people in the home. Staff watch for me coming now so they can help and make sure everything is OK." Staff told us the senior carers and the registered manager were approachable and responded when matters were raised with them. One staff member told us, "They (senior carers and registered manager) are very good, very approachable. You can go to them with anything."

Staff told us they followed the registered manager's example in creating an open, honest culture. We observed there was a homely atmosphere where people were relaxed and calm. There were open and honest discussions between people, staff and managers which staff told us helped people and the staff supporting them to feel valued and respected. Relatives agreed. One told us, "Staff tell me what has been happening. They are very good at sharing information. There is very open communication."

Staff told us they had the opportunity to share their views at staff meetings. Records showed staff had the opportunity to discuss the developing needs of people living in the home and share any concerns they might have. Staff told us they were listened to and that made them more likely to share their views. They told us issues were discussed, actions were agreed and progress on actions was fed back by the registered manager. One staff member told us, "[Registered manager] is so laid back. Everyone says what they think."

The provider had systems in place to gather the views of people, relatives and others with a view to learning more about the service they provided and how it could be improved. However, whilst some relatives told us they had completed questionnaires asking for their views on the service, there was no evidence that this feedback had been analysed or that any action plan had been developed as a result. Relatives told us they were invited to meetings to discuss what was happening in the home. For example, they told us at a recent meeting they had been assured some money would be spent on the upstairs of the home as "All the nice things are downstairs at the moment." Another relative told us, "There are relatives meetings. If I can't attend I get information from them afterwards."

The provider had systems to monitor the quality and safety of the service with a view to improving it, but there was no evidence that these were routinely carried out and the results used to inform an action plan. For example, care plans had not been audited since 28 September 2015, whilst medicines had not been audited since 7 October 2015. The lack of effective and frequent auditing of care plans and medicines meant that some of the inconsistencies we had identified had not been picked up or acted on by the registered manager. Statistics were collated monthly for weight loss and accidents but no corresponding action plans had been developed to address any issues identified. There was also a health and safety audit on record from 7 February 2016. Actions from the audit had been identified, but these had not been risk assessed or time scales for implementation of the actions identified. We discussed this with the registered manager, who agreed audits had not been robust enough to identify the issues we had identified during our inspection. They said they would discuss this with the provider.

Whilst the registered manager told us they felt well supported by the provider, they acknowledged that, since becoming the manager in late 2015, and becoming the registered manager in January 2016, they had found it "…difficult to keep up with being the manager, one of the nursing staff and also trying to recruit." They told us they had spoken with the provider about the difficulties they were experiencing, and so it had been agreed a nurse could be recruited. The registered manager told us recruitment to this post was underway and they felt this would make things easier. However, they told us they had not been able to find time to work on quality checks, audits and care plans so that they were effective as a result of the time pressures they had experienced.

The registered manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months.