Burlington Care Limited

The Elms Care Home

Inspection report

Elm Drive
Louth
Lincolnshire
LN11 0DE

Tel: 01507350100

Date of inspection visit:
24 April 2017
25 April 2017

Date of publication:
23 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected The Elms Care Home on the 24 and 25 April 2017. This was an unannounced inspection. The service provides care and support for up to 86 people. When we undertook our inspection there were 77 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses, mental health needs or because they were experiencing difficulties coping with everyday tasks, with some living with dementia.

There was a registered manager 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection we looked at the records of three people who were subject to such an authorisation. Some staff were unsure of the practicalities of implementing MCA legislation.

We found that people's health care needs were assessed. However, the recording in the care plans was not consistent. People and their relatives (where appropriate) were not always involved in the planning of their care. The information and guidance provided to staff in the care plans was unclear and staff did not always complete charts as they were supposed to. Risks associated with people's care needs were assessed, but plans were not put always in place to minimise risk in order to keep people safe. Forward planning for those living with dementia was poor. Staff had received training in how to protect people from harm, but were unaware of how other agencies such as the local authority could be involved in the decision making process.

People had been consulted about the development of the home and quality checks had been completed to ensure the home could meet people's requirements. There was an analysis of quality checks and lessons learnt were passed on to staff. The premises were well kept. There was a maintenance team to ensure areas were kept refurbished and redecorated. A garden team kept the grounds tidy and ensured pathways were free from hazards.

The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period. The home was divided into three different units and a core staff worked in each unit, with some staff working across units depending on people's needs. There was a unit manager in charge of each unit. This ensured there were sufficient staff to ensure the needs of people could be met.

Staff had received training in administering medicines. Medicines were stored safely. However, staff needed to ensure they accurately recorded when medicines, such as creams, had been applied.

People were treated with kindness and respect. Staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. Meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. In two units there were menus on display so people could remind themselves of the choices they had made. In the unit where the majority of people were who were living with dementia resided the staff did not display the menus but offered plated choices of foods at each meal.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. On-going training was available for all staff.

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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse and report this internally, but not which other agencies were involved in decision making processes.

Risk assessments were not always up to date and staff did not ensure people were protected from harm.

Medicines were stored and administered safely. However, the recording of creams which had been prescribed for people to use was not always completed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. However, the timing of drinks in one unit was not always conducive to people joining in planned activities.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not always understood by staff. Not all assessments were in place to ensure staff were aware of people's capabilities.

Forward planning for those with dementia was not evident in the care plans.

Charts were not always completed for monitoring of such needs as weight control and pressure ulcer management.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times. .

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was planned, but not reviewed on a regular basis with them. The care plans did not fully explore the needs of people and how other agencies could help them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

An analysis of audits was undertaken by the registered manager to measure the delivery of care, treatment and support given to people against current guidance. However, more scrutiny of audits undertaken required the registered manager's and registered person's attention to ensure people's needs were being met and the services provided were effective.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors and other health and social care professionals were sought on a regular basis.

The Elms Care 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 the 24 and 25 April 2017 and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals before the site visit.

During our inspection, we spoke with eight people who lived at the service, four relatives, five members of the care staff, two registered nurses, a housekeeper, an activities organiser, a cook, three unit mangers, the administrator and the registered manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at 14 people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the

registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

Most staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. Those that had not yet received their training had been booked on a course. Although staff were unaware of the role of other agencies such as the local authority safeguarding team and CQC, they felt confident the registered manager would take the right action to safeguard people.

Risks to people's health and safety were identified through the completion of risk assessments for such as falls, nutrition, choking, pressure ulcer risk and moving and handling. These were generally reviewed monthly or more frequently. There were a number of areas which required improvement. For example, we found in one person's care plan they had been assessed as a falls risk on admission and had suffered a series of falls after admission. The risk assessment had not been reviewed in light of those falls and the falls care plan had not been updated with additional action to prevent further falls. When speaking with a senior member of staff they were unaware of the person's latest fall and action taken by other staff. There was no documentation to support the actions staff had taken after the person had returned from hospital, such as vital signs checked because of a head injury.

We observed that people who were at risk of falls had beds which could be put on a low setting nearer to the ground. However, we found in one care plan that a person who was at risk of pressure ulcers and had developed one was on a wide bed. Staff told us it had not been possible for an alternating pressure mattress to be placed on the wide bed. Staff told us this was because an alternating pressure mattress was too narrow for the bed. They confirmed the person did not need the wide bed they were on, but could not state why this was in use. This could result in this person developing further pressure ulcers if the right equipment was not in place.

Records for people who required assistance to re-position, to prevent the development of pressure ulcers, were completed consistently. The charts in use had been completed by staff to show when people had been turned in bed and if they had refused to move or were asleep. This ensured the care being given was being monitored for its effectiveness. However, the charts in use for wound management of people's pressure ulcers had not been so consistently completed. For example, there was a dated photograph of a person's pressure ulcer but no wound assessment when the problem had been first identified. Therefore staff had no way of monitoring how effective some treatments had been.

Where people had distressed behaviours which others might find challenging, staff told us they would give the person some space, try and provide them with explanations and reassurance to gain their co-operation. They told us they did not use forms of restraint. Care plans identified when people were resistive to personal care and the actions staff should take when this occurred. The information tended to be generalised rather than giving information specific to a person.

Where there had been incidents where people's challenging behaviour could be harmful to them or others, staff had not always analysed the causes of people's behaviour. For example, when a person continually

walked about the unit looking for something. No consideration had been given to whether the person required an increase of observation or whether this had been discussed with the commissioners of services for this person. This meant staff had no means of knowing the triggers which could result in the person's behaviour and would therefore find it difficult to prevent them and others being harmed. This meant that people could be distressed about this person's behaviour, which staff were not monitoring.

We noted in the unit where the majority of people resided who were living with dementia that staff were not always present in the communal areas. When we spoke with a member of staff about one person who was trying to enter people's rooms their response was that other people lived with dementia and were probably used to it. Also within this unit on both days of our visit a number of bedroom doors were closed. On the second day this was seven rooms. A senior member of staff told us this was to reduce the number of people entering bedrooms and people would not be exposed if they were lying in bed. There was no evidence in the care plans to show risk assessments had been completed to identify potential risks to those people and if they had consented to their bedroom doors being closed. This was a blanket approach by management and did not take into consideration the needs of individuals' and any potential risk to them.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. There was an analysis to show themes and trends, which would help to identify specific safeguarding concerns. Staff told us that changes in care needs were discussed at staff meetings and daily shift handovers, which they said was effective. Each unit kept a written record of the handovers between shifts.

People and relatives told us they felt safe living at the home. One relative said, "[Named relative] is safe here, no doubt about it." Another relative said, "No concerns about that." We observed staff handling situations where people's behaviour was disruptive to others and could put them and others at risk of harm. Staff were calm, talked with each person and offered alternatives to how they would like to spend their time and where they could sit. People told us staff dealt well with those situations and they felt safe. One relative said, "Staff take [named person] away from the area, calm them down and sort it out of the way." They said that removing the person helped that person to be less agitated.

People told us there were sufficient staff to meet their needs. However, one person said, "Staff were overworked this morning; staff were running up and down." A relative told us, "It's difficult to find staff normally, not like today." Another relative told us, "The staffing varies a bit. They get all their jobs done, but don't have the time to sit with [named relative] like I do."

Staff told us that the staffing levels were appropriate to meet the needs of the people they cared for most of the time. They told us that sickness absence meant they could sometimes struggle, but the registered manager would explore all avenues to obtain staff. Staff told us other staff would happily work in other units if staffing absences were low.

The registered manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were reviewed on at least a monthly basis by the registered manager. The registered manager discussed the staffing needs for some people with complex needs with commissioners of services. This was because those people required more input by staff on a one to one basis. We saw in the care plans when those discussions had taken place. Staff informed us of the people who required this extra input and we saw how extra staffing was helping one person to fulfil their needs. There was a contingence plan in place for short term staff absences such as sickness and holidays. The registered manager was aware of the need to ensure there were sufficient staff on duty to meet people's

needs and was working with people who used the service, relatives, commissioners of services and staff to ensure staffing levels were correct. We observed that people were not kept waiting for care and treatment and staff went about their work in an unhurried way.

We saw that recruitment checks were carried out prior to people being employed at the service. The provider asked for references, proof of identification and undertook checks with the Disclosure and Barring Service (DBS) to ensure that people did not have any past convictions that would present them as a risk to people living at the service. At the time of our inspection there were no staff vacancies.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would become anxious when hearing a loud noise. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document. One person told us they were aware fire drills took place. They said, "All the doors bang shut."

We were invited into several people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision.

The main entrance to the home was through a reception area where people either rang a bell to summon staff to enter or who had authorised access. Entry to various parts of the building required a code. Staff told us that people could have access if they had been assessed as being capable of retaining that information, but this was not recorded in their care plans. People could choose to have name plates on their bedroom doors, which enabled them to identify which room was theirs. Some people choose to have pictures on their doors which meant they could recognise them quickly. There were also signs on the doors indicating what each room was used for, for example, a sitting room or toilet. The directional signage around the home was clear and in words and pictures. Each wing of each unit was themed and people told us they liked to describe to friends and relatives that they lived at the home on, for example the music wing.

There was no maintenance plan in place, however, large sections of the home had been refurbished and new furniture and equipment purchased within the last 18 months. We also saw information which had been sent by the registered manager to the head office with requests for new equipment. The registered manager and ancillary staff told us they had never been refused requests for new and replacement equipment such as towels and cooking utensils. This ensured the home was maintained to a good standard at all times. A maintenance and gardening team ensured the buildings and gardens were redecorated and refurbished and pathways kept free of hazards.

People told us they received their medicines and understood why they had been prescribed them. One person said, "Yes I get mine on time." They went on to tell us what was administered and which staff helped them. Another person told us, "I take mine slowly, but staff know that and stay with me in case I'm struggling to swallow." Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in locked areas in each unit. Records about people's medicines were accurately completed, with the exception of some records where creams were to be applied. These had not been consistently completed. For example, one person was described as requiring cream two to three times a day, but staff had only recorded this had been applied four times over an 18 day period. The person could not tell us whether cream had been applied on other days. Therefore we did not know whether the person had received their prescribed medicine in the form of a cream. The registered manager told us they would

give extra instructions to staff about applying creams and how to accurately record events. A separate register was kept for those medicines which were required to be recorded in a separate book and there was accurate recording by staff.

We observed medicines being administered at different times of the day and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage areas.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us they thought the staff were well trained and able to meet their or their family member's needs. We observed a list in the reception area of various staff training dates and also overheard the registered manager explain to a person what training was on offer for staff.

Staff we spoke with who had been newly recruited told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The registered manager told us that all new staff were now registered for the Care Certificate. This would give everyone a base line of information and training and ensure all staff had received a common induction process.

We saw that there was a training system in place commissioned through an external company and by the company's own trainers. This system was flexible and enabled the provider to identify units each year that they felt would be most appropriate to the needs of staff at the time. Staff were expected to work through 'knowledge books' in groups or as part of workshops and then their knowledge would be tested and marked by the training company. This would highlight where more training and development would be needed. There was also regular training around issues such as infection control, manual handling and diversity and equality. The training matrix showed that training for the majority of staff was up to date. Where staff required update training to be completed this was coloured red on a training planner and was raised at individual staff supervision sessions, which we saw recorded. One member of staff was exploring different topics each month. The month of the inspection visit the topic was catheters. They had completed some training sessions with staff and placed on notice boards information for staff to read. One member of staff told us, "This gets it in my head and I can keep referring to the notice board for more information."

Staff told us they could voice their opinions in supervision sessions and felt their opinions were valued. All staff had received at least two supervision sessions this year. Where a staff member required extra supervision sessions we saw this was recorded in their personal files. Registered nurses were independently seeking advice about their revalidation with the Nursing and Midwifery Council (NMC). This ensured they remained on the 'live' register with the NMC and seen fit to practice as registered nurses. The registered manager was checking the progress of the NMC revalidation process with each registered nurse. The registered nurses told us they were supporting each other in the process for revalidation.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. We looked at three authorisations. The provider had provided training and prepared their staff in understanding the requirements of the MCA legislation. Some staff gave us good examples of what this meant for the people they looked after, with the exception of one senior person. As this person was in a position of passing on information to other staff we were concerned this could be inaccurate when passed on. This information was passed to the registered manager during the inspection and they told us they would speak to the staff member. Other staff knew the principles behind how MCA and DoLS affected the people they looked after, but could not explain how this could be recorded or applied practically for people. These are fundamental issues which staff should know.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability for such events such as living in the home and being able to make informed choices about going out on their own. However, in the unit for people living with dementia we did not see other assessments on people's mental capacity such as about taking prescribed medicines and the use of bed rails. For example, we observed that two people were reluctant to take their medicines and we would have expected to see a capacity assessment and best interest decision in relation to this, but there was none. Assessments were not in place in four of the care plans of people who had bedrails in place. There was also no information that a discussion had taken place with the person or their advocate.

People told us that they liked the food. One person said, "Very good meals." Another person told us, "Quite good." Although one person told us they did not like the food and had asked not to be served with gravy, but this had not been adhered to by staff. We passed this on to staff and observed them talking to the person about their meal requests. A relative told us, "Staff ask each morning what the residents would like for the day." Another relative said, "Excellent food, such variety and plenty of it."

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and if they needed assistance. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. Staff had recorded people's loss or gains in weight. However, where people required charts to be in place to monitor their daily nutritional intake these had not always been completed. Staff had not always recorded what people had eaten and drunk at different meal times. Rather than recording amounts of fluid such as drank 50mls of tea staff had recorded "sips". Therefore, staff did not know whether people had consumed enough food and drink to help their health and well-being. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy. Menus were on display in the entrances to two unit dining rooms.

We saw that staff ensured people were well hydrated during the day. People were offered hot and cold drinks regularly by staff, but staff also made drinks for people when asked to do so. However, we observed on one day in the unit where people were living with dementia that staff had not timed the offering of mid-morning drinks and a snack at a convenient time for people. People were in the middle of enjoying a bingo session when staff offered drinks. The people were then confused as to what to do, with some staff asking them to drink and some asking them to continue with their game. Most people stopped playing and drank

instead. This was poor timing on behalf of staff. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required. Each meal was covered over before being carried to rooms. However, we observed that the main meal was served the same time as the dessert. This meant if people had chosen a hot dessert it was going cold before they had chance to eat it.

We observed the lunchtime meal, in three dining rooms, was not rushed. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff were calm, gave encouragement to get people to eat and ensured people had something to eat. For example, one person found it difficult to settle, so staff watched as they ate standing up. We observed that when people had food on their face staff asked whether they could wipe this away, which they did gently. When food had been spilt on clothing staff asked if the person would like to change and guided them to their bedroom. One person was not able to eat and drink orally and had a tube fitted for their nutrition to be administered directly into their stomach. The records showed the nutrition was given in line with the regime provided by the dietician and the person was maintaining their weight. However, there was no record of the regular components of care for this person such as rotation of the tube and change of equipment. Careful monitoring of people's nutritional needs is fundamental to people's health and well-being which staff should know.

We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. People told us they had appropriate and timely access to health care. One relative said, "[Named relative] is going to the doctor's on Friday and staff have arranged the transport for us." Another relative told us, "The paramedics were called and the staff kept a close eye on [named relative] and I was kept informed." We also saw in the care plans evidence of people being reviewed by their GP when they were unwell and attending hospital appointments. However, we did not see any reviews by the community psychiatric nurses and how the effectiveness of treatment for people living with dementia was being monitored by outside agencies. Staff had recorded when people had seen the optician and chiropodist. They told us they had a good rapport with health professionals and felt supported by them when they required assistance. This was affirmed by the health and social care professionals we spoke with before our visit.

Good

Is the service caring?

Our findings

We observed staff greeting people with a smile and approaching people in a kindly manner. They acknowledged people as they walked around the home. They were patient and sensitive to people's needs. For example, when someone asked for assistance to walk back to their bedroom. The person told us, "I can usually manage, but I am a bit wobbly on my legs today." Staff reassured the person and helped them, by taking their arm and walking at the person's pace.

People told us they liked the staff and felt well cared for by them. One person said, "Nothing is too much trouble." Another person told us, "They've been wonderful to me." Another person said, "I could not be any better looked after." A relative told us, "[Named relative] gets spoilt. She is very content." Another relative told us that their family member could not communicate verbally with people. "There are a few staff who are really close to [named relative] and [named relative] will put their hand out to them when they come into the room."

People were given choices throughout the day if they wanted to remain in their bedrooms or bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives and other people, and some with staff. The general mood within all the units was light hearted. There was a lot of laughter and camaraderie amongst the people who lived there, visitors and staff. For example, we observed two relatives joking about the weather and how they could not yet access the beach area which had been developed in the back garden area of the unit for people living with dementia. A lively discussion took place about beach clothing and building sand castles.

Some people either through choose or because they were ill choose to remain in bed. We observed staff attending to people's needs. They ensured they answered people's call bells promptly and politely asked what they required before fulfilling the person's wishes. One relative said, "As soon as I press the buzzer they come and sort it out."

The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, we saw recorded in a care plan when a person liked to get up in the morning. They told us staff adhered to their wishes. Staff told us of various ways they communicated with people who could not express themselves verbally such as with pictures, sign language and hand gestures. For example, one person gave thumbs up or down sign when staff asked them questions. Staff phrased the questions so the person could give either a negative or positive thumbs movement.

We observed staff helping several people whose behaviour was distressing to others. They ensured the staff member who used the call bell system was not on their own and gave reassurance to the person concerned. Other people in the area were either politely asked to move away until the situation was calmer or the

person concerned was asked to move away. This defused the situation and staff remained with that person until they looked more settled.

Relatives told us how staff had supported them when their family members were very ill. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as kind, knowledgeable and treated people with dignity. One relative said, "I can visit anytime, which is great. I am always made welcome." Another relative told us, "From kitchen to carers to laundry staff, they are all fantastic. I cannot highlight that enough."

We saw in care plans where people's life was drawing to a close that they provided a good level of detail about people's wishes in relation to their care. We observed with one person that staff were attentive not only to the needs of the person, but to the family and friends visiting. They spoke in a different room with a visiting GP so as not to distress the person and their family. Staff passed on messages of kindness other people living in the home had asked them to pass to the person.

People told us staff treated them with dignity and respect at all times. One person said, "When I want a bath they ensure all my special toiletries are in place." We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of care being given. Staff were able to identify the steps they took to protect people's privacy and dignity. For example during helping with personal care and closing doors and windows.

We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. There was a separate signing in book in the unit for people living with dementia as this building was a separate building within the grounds.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care. This could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit.

Requires Improvement

Is the service responsive?

Our findings

The home was split into three units and the registered manager told us people were assessed with a view of initially staying in the unit which best suited their immediate needs. As staff became more familiar with people's needs and wishes there was then opportunity for them to move to a different unit within the home. This made it easier for outside agencies to assess the appropriateness of placing people within the home.

In the care plans we looked at the placement criteria for people was recorded. Therefore, it was clear why they were at the home and if the setting was appropriate to their needs. There was a history of people's needs leading up to their placements at this home. In a care plan for one person, who had complex needs we saw there had been many incidents where staff had intervened due to their challenging behaviour. Staff were aware of what type of intervention had worked in the past and whether the person would require extra funding if more staff were required to monitor this person's behaviour.

The content of the care plans varied in terms of the level of detail and the extent to which they provided details about the people's preferences in relation to their care. For example, a person was experiencing problems with a catheter. Although it was clear that staff were providing care and seeking specialist advice when problems occurred, other information was absent. This included the type and size of catheter required (so as not to cause the person distress), when bladder washouts were needed and how the situation was managed.

In the care plans there was no clear information on plans for people's health and well-being over a period of time. For example, where people had physical needs, such as mobility problems which were affecting their mental health. In one care plan we saw a person had mobility problems and was in bed during the two days of our inspection. The care plan recorded the person's wishes to get out of bed daily to take part in activities in a sitting room. However, staff told us that the person only was out of bed every other day, but staff had not recorded if the person had been offered help to get out of bed or staff had made that decision of their behalf. Staff told us, "it depends on their mood" and "they can usually say what they want." The care plan did not record the person's mood swings and had not been updated to reflect their frailty at this time.

The wording in the care plans showed the care plans were written with people, as opposed for them, but people's views not being consistently recorded. Care plans were not always dated when they were written, although the date of the first evaluation provided an indication of the date. Care plans were handwritten and although most were legible, we experienced some difficulties with the legibility of three care plans we reviewed. Staff told us care plans were to be updated every month, but this was not so for all care plans.

The people we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. People told us staff responded quickly when they used their call bell, day and night.

We were informed that three activities co-ordinators were employed each week. This ensured that social activities could take place seven days a week as the hours were flexible. Staff told us activities were arranged

through consultation meetings with people. A programme was on display for April 2017 in each unit and we saw the advertised activities taking place. These included baking cakes, making cards and a music and singing session. Staff told us the activities coordinators tried to concentrate on one to one activities with people in a morning and group events in the afternoons when more people were up. The photo album showed a number of different activities which had taken place over a period of time. The registered manager told us all the craft work on display around the home and been completed by the people living there with the help of the activities co-ordinators. This was confirmed by some of the people we spoke with during the inspection. The home used to have its own mini bus, which made it easier for people to access local events, but this was no longer available to them. The registered manager told us they were looking into alternative ways of getting people out into the community such as a local taxi service and asking other homes in the group for the loan of their mini bus.

The activities co-ordinators kept separate records on the activities people had taken part in. Along with daily notes they kept life maps showing people's involvement with family members, friends, their school lives, previous work experiences and hobbies. Some had special stories in the files such as events they had taken part in. Staff told us the information had been gathered in conjunction with each person and their family members to paint a full picture of the life of each person. Staff told us they used this to engage in meaningful conversation with people. We observed staff using the life maps when speaking with people. A separate café had been set out for people to use for meetings and other events. This had a dining section and soft furnishings for people to relax in with their families. Relatives told us they could use it for more private parties and for family discussions. Links with the local community had been encouraged. There were visits by the local schools. Singers, musicians and seated exercises also took place. People told us they visited the local shops and pub visits. A newsletter provided up to date information about forth coming events, competitions and the tuck shop for people to be able to purchase personal items.

The provider had a system for managing complaints and this was available in the entrance of the service for people to access. We reviewed the complaints information and the records of any formal complaints having been made in the last year. These complaints had been dealt with appropriately. People and relatives told us they could speak to any staff about their concerns and they knew the registered manager had an open door policy and would see them at any time.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. People and relatives told us they could express their views to the registered manager and felt their opinions were valued in the running of the home. We observed the registered manager interacted politely with people and people responded to her in a positive manner. One relative said, "The manager always makes time for you." Staff told us they felt supported and could influence change when speaking with the registered manager. A notice in the main reception gave details of an "open surgery" the registered manager had each Friday.

There were unit managers in position in each unit. With one deputising for the manager when she was away. Each one knew a lot about the people in their units and their staff. They told us they had a certain degree of autonomy in each unit as each was so different. Staff told us they could speak with the unit managers at any time. One staff member said, "They do run the units, but they work alongside us so they can get a feel of how people like to be cared for here."

Systems for auditing and monitoring the service were in place. These included areas such as the kitchen, infection control, mattress audits and medicines. Each one had the facility to create an action plan. When these had been written they gave clear instructions on what staff should do and why. Once the actions had been completed these had been signed as such by the auditor. Some staff told us they were not involved in the audit process, but would be told if they needed to be part of any action which was required. They told us a system entitled "resident of the day" had commenced. This meant that in each unit a person's care plan had to be evaluated and audited each day. As there were less than 30 people in each unit, this meant everyone's care plan would be audited at least once a month. Staff liked this system and felt they were given time to do this on the days it fell for them to complete the task. Some staff had extended roles such as an infection control lead, dementia champions and tissue viability lead. They told us they researched each topic and passed on information to other staff. However, there was no analysis of the work of the extended roles of staff to see how effective they were for the benefit of people using the staff and the support of staff.

However, more auditing processes undertaken by staff, such as registered nurses and the cook, other than the registered manager needed further scrutiny. Such as risk assessments, best interest meetings and care planning. This would ensure the needs of individuals were constantly being reviewed. The registered manager and registered person should have oversight of those and ensure it is being managed effectively to protect people from harm and ensure their needs are updated. There was also no analysing and learning from incidents when information had been passed to staff, which is a fundamental part of good quality assurance.

There were records in place to show the registered provider's regional representatives visited the home on a regular basis. Visit notes showed topics covered included speaking with people, staff and looking at records. These included weight monitoring charts, the registered manager's audits and daily charts. When actions were required these showed when they had been completed. The registered manager told us they felt relaxed in the company of regional representatives and able to voice their opinions, which they felt were valued.

The provider held meetings with people to gather their views about the running of the service and the notes from the meetings showed that much of the discussion was around activities, the delivery of care and laundry. A relative told us they attended the meetings and were able to make suggestions for improvement. They were then told about any changes which had been made.

Staff meetings were held and minuted. Staff varied in their comments about the frequency of the meetings. One staff member expressed to us that they would like the times to change so they could mix with staff who only worked certain shifts. We saw the minutes of a variety of meetings which had been held with staff. These included activities co-ordinators, unit managers, registered nurses, care staff and housekeeping staff. Each had a variety of topics which had been discussed. Staff had been given opportunity to express their own views.

We saw that the results of the January 2017 people's survey had been displayed around the home. This was displayed in a graph form and also in words. One section was described as "You said" and the other "We did". For example people said there was an occasional smell of urine. Under "We did" it stated they had asked the cleaners to be a little more aware. The results of the January relatives and professionals survey was also on display. These showed positive comments had been made by each party for topics such as being treated with respect, cleanliness, staff being supportive and information sharing to enable other professional agencies to be able to complete their role.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.