Hamton Crest Limited

Mayflower Care Home

Inspection report

Hartshill Road
Northfleet
Gravesend
Kent
DA11 7DX
Tel: 01474 531030
Website:

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Ratings

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

Overall summary

This inspection was unannounced and took place over three days on 5, 6 and 9 March 2015.

Mayflower Care Home provides accommodation, nursing and personal care for up to 76 older people. There were 65 people living at the service at the time of our inspection. Some people are unable to move independently, whilst others need support due to illness or other age related conditions. Some people are able to express themselves verbally, whilst others use body language and other types of communication. The service is divided into five units and each one aims to meet people's specific needs. For example, one unit provides care and treatment for people who needed nursing care and people nearing the end of their lives. Another is designed to support people with complex needs, such as people living with dementia with mental health problems and behaviours that challenge.

Summary of findings

The property is purpose built with flat access and adaptations suitable for people with restricted mobility. Each person has their own bedroom with en-suite facilities. Accommodation for people is over three floors accessed by passenger lifts.

When we last inspected the service on 5 February 2014, we found that the service was not meeting the Health and Social Care Act (Regulated Activities) Regulations 2010. People's consent and their lack of capacity to consent to care and treatment was not recorded. Care plans did not contain guidance for staff about how people preferred to receive their care. At this inspection we found that breaches from the last inspection had been addressed.

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

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People's welfare was not always safeguarded by sufficient numbers of suitably qualified, skilled and experienced staff. The number of staff on duty and/or their deployment within the service did not always meet all the needs of all people in a timely manner. The shortfall in permanent staff affected the delivery of care for some people.

People were not always protected against the risks associated with the unsafe use and management of medicines. Safe medicine administration procedures were not always followed and could put people at risk.

The areas which accommodated people living with dementia contained some notices to help orientate people. However, the environment was not specifically designed to aid orientation for people living with dementia. We have made a recommendation about this.

There were activities organised in which people could participate. However, these were not always sufficient or specific enough to meet people's differing needs or preferences and prevent social isolation. We have made a recommendation about this.

Staff knew the correct procedures to follow. However, policies and procedures did not provide staff with written up to date best practice guidelines, including any changes in legislation. We have made a recommendation about this.

The registered manager had a good understanding of how to work with, and follow advice from the local safeguarding authority to protect people. Staff identified and managed risks to people's safety. People lived in a clean environment. Staff had a good understanding of infection control practice and took measures to ensure that the service was clean and free from the risk of infection. The provider ensured that the premises were maintained safely and securely.

The service operated safe recruitment procedures which made sure staff employed were suitable to work with people. Staff had the appropriate skills and experience to meet people's needs. They were able to put this into practice by using the knowledge they had gained from training. Staff were supported to work to expected standards through supervision.

Staff sought people's consent before they carried out any care tasks. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. The system for monitoring Deprivation of Liberty Safeguards (DoLS) within the service protected people from harm and protected their rights.

People were supported to have a choice of food and drink and could choose where they had their meals. Staff took action to reduce the risk to people from poor nutrition and dehydration. People were supported to manage their health care needs and had access to health care professionals, such as a G.P. They were referred to specialists or for hospital treatment where necessary.

People told us they liked their bedrooms and the environment in which they lived. There were various communal areas where people could spend their time.

Summary of findings

Staff treated people with kindness. People were supported with their preferences and involved in their care planning in their day-to-day lives. Staff demonstrated respect for people's dignity and were careful to protect people's privacy. Staff promoted people's independence. Specialist care was provided for people who were nearing the end of their lives.

People who were considering moving into the service were assessed to determine if the service could meet their needs. People's care was personal to the individual and care plans provided guidance for staff about people's preferences and how they wanted their care to be delivered.

Staff communicated effectively with people, responded to their requests and offered people choices.

The provider had a clear set of vision and values. The service had a clear, accountable management and staffing structure. The service had a welcoming, pleasant and busy atmosphere. People, staff and their relatives thought the registered manager was approachable.

People, their relatives, members of staff and professionals associated with people's care were asked for their views about how the service was run. These were acted on to improve the service provided. The manager investigated and responded to people's complaints and concerns. There were regular audits to review the quality of care and safety of the premises.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Safe medicine procedures were not followed by staff.

There were not enough staff employed or deployed to meet people's needs.

The provider had taken reasonable steps to protect people from abuse and operated safe recruitment procedures.

Risks to people's safety and welfare were assessed and managed.

Requires improvement

Is the service effective?
The service was not consistently effective.

The environment was not specifically designed to aid orientation for people living with dementia

Staff were supported in their roles with training and supervision.

The service complied with requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were supported to manage their health care needs.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with kindness, dignity and respect.

Staff protected people's privacy.

Staff promoted people's independence.

Specialist care was provided for people who were nearing the end of their lives.

Good

Is the service responsive?
The service was not consistently responsive.

Activities were not sufficient or specific enough to meet people's different needs.

People had choices in their day to day lives.

Staff communicated effectively with people.

People's concerns and complaints investigated and action was taken.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

Policies and procedures did not provide staff with written up to date best practice guidelines.

The service had a welcoming, pleasant and busy atmosphere.

People, their relatives, members of staff and professionals associated with people's care were asked for their views about how the service was run.

There were regular audits to review the quality of care and safety of the premises.

Mayflower 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 5, 6 and 9 March 2015 and was unannounced.

The inspection team included two inspectors, one pharmacy inspector and one specialist nurse advisor. The team also included an expert by experience, who is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in this inspection had specific knowledge of caring for older people.

This inspection was carried out in response to concerns from people's relatives and the local authority. These included the management of people's medicines and staffing levels. We found that improvement was required in these areas.

Before the visit we examined previous inspection reports, information and notifications we had received about the service. A notification is information about important events which the provider is required to tell us about by law.

We spoke with nine people who lived at Mayflower Care Home, five of their relatives and eight members of staff, including nurses and care staff, one shift co-ordinator, one member of staff employed to provide activities and one employed for domestic duties. We spoke with the registered manager.

We observed staff practice and the care that was provided within the service. Some people who were living with dementia were not able to tell us about their experience of living at the service. To help us to understand the experiences people had, 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 records that included six people's files, care plans and risk assessments, 10 medicine records and staff files. We also looked at staffing rotas, training records, health and safety checks, accident and incident records, quality assurance audits, surveys, meeting minutes and policies and procedures.

At our last inspection of 5 February 2014 we found the service non-compliant with the treatment and care and welfare of people and people's consent to care.

Requires improvement

Is the service safe?

Our findings

People and their visitors told us that they felt people were safe at the service.

People had mixed views about whether there were enough staff on duty. Some people thought there were enough staff, whilst others told us "There are not enough staff and less at weekends" and "Staff do not have a lot of time to chat."

Some staff thought there were sufficient staff on duty, whilst others said "This could be a really great care home but there are not enough staff" and "I have to keep my eye on the clock all the time". Some staff thought there were enough staff generally, but there were not always sufficient staff in the right places at the right times. For example, problems arose when two staff were supporting people in their bedrooms and an incident occurred in a lounge, with only one member of staff supervising that area. One member of staff told us "Sometimes we're busy…there are four carers and one nurse. We should have a shift co-ordinator but there is a vacancy. There are four people in the evenings and six in the mornings that need assistance during meals." One member of staff told us that people with behaviour that challenged had higher staffing levels to meet their needs, but felt that the nursing needs of people, without behaviour that challenged were not always met, because of lower staffing levels.

People told us that when they used their staff call alarm, the amount of time it took for staff to respond varied. A visitor said "They are quick to attend to my relative's needs". People told us "Staff come quite quickly but they seem to be very pushed at times" and "Buzzers are answered but the time can vary from being quite quick to waiting 20 minutes". A staff member told us how they felt stressed being unable to respond consistently in time to people's request for help with their personal care, and how this impacted on people's dignity. We observed that staff were not always able to spend time with people in a relaxed and unrushed manner.

People told us that permanent staff were "Really good." Several people commented on the changes in the staff team and use of agency staff. They said "There are lots of changes in staff" and "Night staff are mostly agency, they come and go, come and go and are not much help". One visitor told us "There is a core of staff who look after my relative, but quite a few of the regulars left last year and early this year". At the last 'Residents and Relatives' meeting in February 2015 some relatives said that people living with dementia related better to faces they knew, but there had been a lot of changes with new staff and staff supplied by agencies. One member of staff told us "…when we get agency staff in, it makes the job harder. Good people move on and have to start over again."

The registered manager told us there were vacancies for nurses and care staff both during the day and at night, and it was difficult to recruit and retain staff. The registered manager carried out an assessment procedure once a week, to analyse people's individual needs and from this decided how many nurses and care staff were to be on duty, and where in the service they were deployed. There were more staff available per person to support people living with dementia and behaviour that challenged. However, it was clear from speaking with people, their relatives and staff and our observations that the registered manager's assessment of the number of staff required to meet people's needs was ineffective in recognising where the shortfalls lay. Shortfalls were ineffectively managed as the number of staff on duty and/or their deployment within the service did not always meet all the needs of all people in a timely manner. It was clear that the shortfall in permanent staff had an adverse effect on some people.

People's health, safety and welfare was not always safeguarded by sufficient numbers of suitably qualified, skilled and experienced staff. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system to ensure safe recruitment procedures, which the registered manager made sure were followed in practice. Checks were carried out before staff started work to make sure that they were suitable to care for people. Staff members had provided proof of identity and an employment history. References and checks using the disclosure and barring service (DBS) had been taken up before staff were appointed. The DBS check identified if prospective staff had a criminal record or were barred from working with children or vulnerable people. One member of staff told us "I had to complete an application form and provide two references. One of them was my previous employer. I had to have the DBS back before I started

Is the service safe?

work." All staff were subject to a probation period before they became permanently employed and to disciplinary procedures if they behaved outside their code of conduct. This made sure that they continued to be suitable to care for people after their employment.

The management of medicines at the service was inconsistent. Some areas of the management of medicines required improvement. For example, an oxygen cylinder in one treatment room was not secured or within safety guidance for this type of appliance. This was a potential risk to people and staff.

Medication administration records (MAR) were required to be completed by staff when they had given people their medicines. Due to unforeseen circumstances on the day of our inspection, when staff were dealing with urgent matters, six signatures had been missed on the MAR. It was unclear from this whether people had not received their medicines or whether staff had forgotten to sign the MAR. There had been no omissions on any other day during that week.

Medicines were not always given as prescribed. Two examples of this were that one person was prescribed a medicine, which needed to be taken separately from other drugs, but the MAR showed that this had been given at the same time as other drugs. Staff were not able to confirm that this medicine was given to the person appropriately, by separating it from other drugs. On one occasion a drug used to treat asthma had not been administered.

Some people were prescribed medicines 'to be taken when required'. There was incomplete written guidance for staff about when it was appropriate to give people these medicines. Staff relied on verbal communication between each other to know how and when people needed some medicines. For example, where people were prescribed eye drops, there was no written guidance for staff to indicate into which eye these were to be applied. Staff could not find one person's eye drops, which should have been available to use when required, as they had not been used recently. This meant that if the medicine did become required the staff would not have been able to give the person their eye drops.

Two people were receiving their medicines covertly, for example hidden in food or drink. There was a complete record of the decision making process and who was involved, including the G.P., family member or advocate and the pharmacist. However, these documents had not been reviewed since January 2014 and some of the medicines included in the document were no longer prescribed. Because of this, these two people were not protected by appropriate decision making processes in relation to some of their medicines given covertly.

The registered manager was in the process of assessing and 'spot checking' staff who administered medicines, to make sure that they were knowledgeable enough and competent to do so. However, it was clear from our observations, speaking with staff and examination of records that further action and improvement was required to protect people.

People were not always protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the management of medicines were managed appropriately. For example, people were given medicines that were safe to use, as they were stored at the correct temperature and were within their expiry date. There was comprehensive recording of medicines which were applied as patches to people's skin. This reduced the risk of people having skin irritation from a patch applied in the same place or overdose from two applied at the same time. There was provision within the service policy for people to carry medicines with them if required, such as inhalers for asthma with the consent of their GP. The medicines policy and procedure provided up to date guidance for staff as it was reviewed in February 2015. The staff knew the contents of the policy and where they could access it if they required further guidance.

People told us they could talk to staff if they had any concerns. One person told us "I can talk to staff if I'm worried about anything and they look after me." Staff were trained in how to safeguard people and described how they would recognise signs of abuse. There were information leaflets available for staff guidance about what to do if abuse was suspected, how to protect people and how to report this. Staff told us that they would report any issues immediately if they thought there were concerns about the safety or well-being of any person. There were systems in place to make sure safeguarding concerns were

referred to the appropriate agencies, such as the local safeguarding authority and the police. The registered manager had a good understanding of how to work with, and follow advice from the local safeguarding authority to protect people.

People were assessed individually to identify risks to their safety. These included falls, restricted mobility, the risk of developing pressure sores and behaviour that challenged from people living with dementia This was recorded in people's care plans, together with guidance for staff about how to reduce the risk for people and protect them from harm. For example, staff were aware of the circumstances that could trigger people's behaviour that challenged. Staff knew that some people living with dementia could become agitated or distressed. Staff described how they managed these situations, including de-escalation and specific interventions to protect people. We observed staff intervene and distract a person before an incident occurred. A visitor told us that they felt their relative living with dementia was safe, well cared for and that their behaviour that challenged was well managed. They told us "They are caring. They do not leave my relative when they are anxious and they do a lot of walking and staff walk with them."

There was a system in place to manage accidents and incidents. These were recorded by staff and brought to the attention of the registered manager. The registered manager analysed the records to check for common triggers or hazards, so that any lessons could be learnt and further risks to people reduced. For example, analysis showed that several people had fallen unobserved in their bedrooms. Following this, people identified at risk and their bedrooms were assessed and the results shared with staff, so that they were aware what action to take to try to avoid further accidents and incidents. Records were checked by the registered manager after 12, 24 and 48 hours to make sure that action was taken where necessary, to reduce the risk for people.

People told us their bedrooms were kept clean and tidy and that staff cleaned all areas of the service regularly. Staff had a good understanding of infection control practice and took measures to ensure that the service was clean and free from the risk of infection. They demonstrated this by appropriate hand washing and by wearing personal protective clothing. Staff had access to stocks of protective clothing, continence supplies, bed linen and towels, which were replenished regularly by the domestic team. Laundry staff were knowledgeable about how to protect people from infection. They knew the procedure for washing soiled laundry, reducing the risk of cross contamination. Domestic staff were aware of how to use and store chemicals hazardous to health, such as cleaning fluids. There was guidance for staff to follow, which meant risks were reduced as they knew what to do in the event of an accident.

The premises were well decorated and maintained. The provider ensured that the premises were maintained safely and securely. For example, during our inspection a lock on a medicine cupboard was repaired. Appropriate windows restrictors were in place to ensure people's access to windows was safe. Radiators were boxed in to protect people's skin from the heat. Doors were opened by keypad and alarmed to protect people who became easily disorientated in their surroundings.

Safety checks were carried out at regular intervals on equipment and installations, such as sluice machines and wheelchairs, to protect people from the risk of harm. Action, including testing the water temperatures, was taken to protect people from the risk of scalding and Legionella. Gas appliances were checked as safe. Checks were carried out to make sure that food was prepared and cooked for people safely.

Equipment for assisting people to move around safely was checked by a specialist organisation recently. They found three pieces of equipment to be faulty. The registered manager told us that they were waiting for repairs to be completed. In the meantime, arrangements had been made to hire equipment, so as not to adversely affect meeting people's needs. These arrived during our inspection.

Fire safety systems were in place. Each person had a personal emergency evacuation plan for the risk level associated with evacuating them safely in the event of a fire. This was kept near the main entrance for fast access. Staff knew about the different needs of people, including those living with dementia and those needing nursing care, in the event of an emergency. Staff were trained in how to prevent a fire and some had taken part in a recent fire drill. There were regular checks of emergency exits, fire doors, the fire alarm and firefighting equipment. The emergency lights were last checked in December 2014. The registered manager told us that the next checks on the fire alarm,

Requires improvement

Is the service safe?

emergency lights and staff call systems were booked with a specialist company to take place in February 2015. People's safety had increased because following a fire risk assessment carried out in August 2014, the recommended actions had been taken.

Requires improvement

Is the service effective?

Our findings

People and their visitors told us that the staff provided good care. People told us "The quality of care is very good" and "This place is warm and comfortable and I am well fed and well looked after" and "I would recommend the home to someone. Overall the care is very good" and "Staff look after you, some better than others." Visitors told us "The care is excellent" and "We're very happy with the care and support provided."

People and their relatives told us the staff provided a good quality of care. Staff told us they were provided with the training they needed. Staff were assessed to make sure they had understood the training and knew how to carry out their roles competently. Training was scheduled annually, and the registered manager maintained an accurate record, to ensure that staff completed all the training they needed within the year. Essential training for staff included how to move people around safely, how to prevent the spread of infection and nutrition and hydration. Staff received specialist training in how to care for people living with dementia and people with behaviour that challenged, where this was relevant to their role. This helped them to understand and meet people's needs. Staff were observed using their understanding of each person to communicate with them in a way that helped them to understand and respond appropriately. For example, one person living with dementia did not communicate verbally, but staff anticipated their actions by knowing their behaviour. Staff were able to meet people's needs in practice by using the appropriate knowledge and skills they had gained from training.

The different specialist areas of trained nurses, such as general nursing and mental health, supported the needs of people living with dementia and/or those needing nursing care. Nurses told us they were supported in their professional development and their skills were assessed on an on-going basis. Care staff had the opportunity to develop their skills by obtaining relevant qualifications in health and social care. One nurse told us they were in the process of doing an MSc in public health. They had a good knowledge of how to prevent the spread of infection, how to care for people with wounds and those needing special diets.

All new staff were provided with induction training, when they first started to work at the service. One member of staff told us "Induction training is good and detailed. It included health and safety, safeguarding and MCA (Mental Capacity Act 2005). You are not allowed to start until you've done the moving and handling training." Induction training included shadowing experienced staff, which gave them the opportunity to get to know people and observe how to provide the care that people needed, in the way that they wanted to receive it.

Staff told us they felt well supported and could talk with the registered manager or senior staff when they needed to. One member of staff told us "We have one-to-one supervision, which is helpful." Supervision meetings were scheduled throughout the year, which gave staff the opportunity to discuss any concerns they had and receive feedback about their work and performance. The registered manager maintained an accurate record of staff supervision meetings to make sure that staff continued to work to the expected standards.

We observed and people told us that staff asked for their consent before they carried out any care tasks. Staff understood the importance of obtaining consent from people before care or support was provided. Staff told us that although some people were living with dementia, they could with support and encouragement make decisions about the care they received. They were aware that a person's ability to consent could change. Hand written care plans were signed by people with capacity, as agreement to their care planning and the assistance they received from staff.

Staff were trained in the MCA and Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated a good understanding of the process to follow when people did not have the mental capacity to make certain decisions. For example, some people had been assessed as lacking the capacity to consent to moving from one unit within the service to another. A decision was taken in their best interest to move them to a unit where their needs would best be met. Mental capacity assessments were recorded in people's care plans for staff guidance. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of DoLS, which applies to care homes. These safeguards protect the rights of people who lack capacity,

Is the service effective?

by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect them from harm. The registered manager was knowledgeable about DoLS procedures. For example, in relation to doors that were opened by keypad to protect people who became easily disorientated in their surroundings, and the use of bedrails to prevent people coming to harm by falling from bed. They had sought advice from and submitted applications to the local authority and these were updated where necessary as people's needs changed. The registered manager was in the process of sending updated DoLS applications, which were due for completion by 31 March 2015. The system for monitoring DoLS within the service protected people from harm and protected their rights.

People told us they liked the food and had a choice of meals. People told us "The food is hot and excellent – really good. They always provide plenty of juice and tea and I can have sandwiches and biscuits in-between meals" and "The food is generally quite good." One person told us that if they did not like the food on offer then it would be changed to something they did like. The menu showed two choices for lunch. We observed people enjoyed their food in one dining room, all of whom were eating one choice of meal. Staff told us that they had all chosen this the previous day. Drinks were readily available for people in their bedrooms. People could choose to eat in the dining areas or in their bedrooms. A person told us that they preferred to eat in their bedroom and was joined for lunch by a friend several times a week. People were supported to have the food and drink they liked and could choose where they had their meals.

We observed that staff assisted people to eat and drink where necessary, communicated with them in a way they could understand and respected people's pace by not rushing them. People's independence was promoted by the use of specialised equipment where necessary, such as plate guards and adapted drinking vessels.

The food and fluid that people had, and their weight was monitored and recorded regularly if necessary. From this staff were able to tell if a person was getting enough to eat and drink or had lost a significant amount of weight. Staff knew about and made sure people received food that was within any dietary restriction, such as for diabetes. Staff took action to reduce the risk to people from poor nutrition and dehydration by, encouraging people to eat and drink and referral to a dietician where necessary.

Care plans contained information and guidance for staff about how support people's health needs and medical conditions. Visitors told us that their relative received medical care when they needed it. People had appointments with health professionals such as G.P.s, chiropodists, dentists, opticians and specialists, such as wound care nurses. People told us that G.P.s and if necessary emergency services were called out when necessary. Staff followed guidance in people's care plans to prevent and treat pressure ulcers. People were provided with specialist equipment, such as beds, mattresses and cushions. Staff monitored and supported people to manage their health care needs.

If people needed to go to hospital for treatment, relevant information was taken with them. This made sure that health care professionals knew about people's needs and medicines. This included advice about how to communicate with people. For example, for one person, information included the need for people to talk slowly and clearly and as their speech was difficult to understand, they made themselves understood best by the use of non-verbal communication and writing things down. People were supported with hospital appointments and admissions.

The service was divided into five units and each one aimed to meet people's specific needs. For example, one unit provided care and treatment for people who needed nursing care and people nearing the end of their lives. Another unit was designed to support people with complex needs, such as people living with dementia with mental health problems and behaviours that challenged. The property was purpose built with flat access and adaptations suitable for people with restricted mobility.

The building consisted of four floors, with the kitchen and laundry in the basement. Accommodation for people was over three floors accessed by passenger lifts. Each person had the privacy of their own bedroom with en-suite facilities. People told us they liked their bedrooms and the environment in which they lived. There were various communal areas where people could spend their time. Each floor had designated lounge and dining areas for people to use. Corridors, communal rooms and bedrooms

Requires improvement

Is the service effective?

were a suitable size to accommodate people who used wheelchairs and for the use of equipment to assist people to move around safely. Some corridors broadened into wide areas where the walls were painted with large murals for people to enjoy. The areas which accommodated people living with dementia were suitable to meet their physical needs. Some notices to help orientate people were in place for identifying the lounge and toilets. However, the environment was not specifically designed to aid orientation for people living with dementia, such as with colour contrasts and personalised bedroom doors.

We recommend that the registered manager seeks and follows current best practice in relation to the environmental design, best suited to the needs of people living with dementia.

There was an enclosed garden to the rear of the building and to the front a small garden, both of which were accessible for people using wheelchairs. People were provided with equipment according to their individual needs, which helped them to move around safely.

Good

Is the service caring?

Our findings

People and their relatives described the staff as caring and friendly. People told us "Staff are caring and treat my relative beautifully, they are always friendly and sometimes almost affectionate" and "Staff are very kind, caring in a respectful way, more like your own family really" and "You've only got to ask and anyone will do anything for you" and They do little things to make you feel cosy…I feel as though I matter- real person" and "Staff are polite, respectful and kind" and "Never heard a bad word spoken to anyone" and "Some staff are friendlier than others but none are unkind." One visitor told us "Staff treat my relative with dignity."

Staff treated people with kindness and supported them in a calm manner. People's individual care was planned and regularly reviewed to make sure their needs were understood by staff. Each person had an individual care plan, which was updated if people's needs or preferences changed. Personal records included people's life history, likes and dislikes and preferred daily routines. People were supported with their preferences and involved in their care planning in their day-to-day lives. They had choice about when to get up and go to bed, what to wear and what to eat. During our inspection, there was a religious service for people who wanted to attend. One person's care plan was specific about their cultural needs and they were able to converse with a member of staff who spoke their first language. Staff were trained in how to value people's equality and diversity.

At the last 'Residents and Relatives' meeting in February 2015, people were asked to contribute to changes in people's care plans to provide more personal history and background information. Relatives said they felt involved and had been consulted about their family member's likes and dislikes and personal history. They said that the service communicated well with them.

Staff promoted people's independence and encouraged people to do as much as possible for themselves. Whilst most people needed assistance with their mobility, some people were able to move around the service independently using mobility aids. A person told us that staff helped her to maintain walking independently and to keep mobile. A visitor said that their relative was encouraged to eat without assistance, so as to maintain their independence for as long as possible. A person told us "Staff make you do what you can do - they let you cope if they think you can." We observed staff brought a person to a table in a wheelchair, but then let them manoeuvre themselves into their preferred position.

There was friendly interaction between people and staff responded positively and warmly to people. Staff called people by their preferred names. Staff explained to people what they were doing, such as when assisting people to eat or using equipment to help them to move. They did this in a way that people understood. We observed staff anticipate and understand the needs of people with limited communication in a caring manner.

People told us that staff treated them with dignity and respect. Staff demonstrated respect for people's dignity. They were discreet in their conversations with one another and with people who were in communal areas of the home. The service had a hair dressing salon available for people. A hairdresser visited the service during our inspection. People who were not able to leave their bedrooms were able to obtain their choice of small items, such as toiletries or sweets. Staff provided a trolley service and visited people in their bedrooms.

Staff were careful to protect people's privacy, for example by making sure that doors were closed when personal care was given. Any treatments people needed were carried out in private. Staff knocked on people's bedroom doors, announced themselves and waited before entering. People were able to spend private time in their bedrooms when they chose to throughout the day. One person told us that some people living with dementia used to go into their bedroom without being asked, but that this was resolved as they now had a key to their bedroom. We observed staff distract one person appropriately from entering another person's bedroom.

Specialist care was provided for people who were nearing the end of their lives. Guidance was available for staff in people's care plans. Some people had advanced care plans or 'Do Not Attempt Resuscitation' (DNAR) forms in place. The latter had been completed correctly and signed by an appropriate health care professional. Some staff were trained in how to support people nearing the end of their lives. Staff treated people and their relatives with genuine compassion.

Good

Is the service caring?

Staff were aware of the importance of maintaining confidentiality and discretion. People's information was treated confidentially and personal records were stored securely.

Requires improvement

Is the service responsive?

Our findings

People told us "Staff do listen to me and respond" and "Some days if I'm not so good I ask for help and get it."

People told us "I definitely have a say. You've got a choice" and "Staff ask me what I want" and "They don't pressurise you – you don't have to do something." Visitors told us "There are flexible routines" and "Staff know my relative's individual care needs."

People who were considering moving into the service were visited by a member of the management team and they were provided with information about the service and the care available. They carried out an assessment of their individual needs to determine if the service was able to meet these. A detailed care plan was developed after people moved in, about how to meet their long-term needs. Care plans identified what support and care people required each day. People's care was planned according to their individual requirements and staff knew about people's preferences and how they wanted their care to be delivered. People's care was personal to the individual and care plans provided guidance for staff about people's preferences and how they wanted their care to be delivered.

Staff communicated effectively with people, responded to their requests and offered people choices. For example, staff asked people what they wanted to eat and drink and where they wanted to have their meals. Staff knew people well and were able to describe the kind of support each person needed and how they preferred to receive this. People's choice and preferences were respected. For example, some people liked to get up early and some preferred to be left to have a lie in. One person preferred a cup of tea before their dressings were changed and staff responded to these requests.

Staff discussed each person's needs when they handed over to the next shift, highlighting any changes or concerns. We observed staff finishing their shift in the morning giving detailed information about each person to staff starting work in the afternoon. For example, changes in people's physical, social and mobility needs, their medicines and skin integrity. Because of this, staff knew about changes in people's needs and how to respond to meet them consistently.

People told us that they liked their bedrooms. People were actively encouraged to bring belongings from their previous home, such as ornaments, pictures and photographs. People's bedrooms reflected their personality, preference and taste.

People's care plans contained information about their background and interests, how they preferred to spend their time, what they liked to do and how they preferred to socialise. Staff knew about the personal histories and interests of each person they cared for. However, this information was not used to provide people with individual activities which considered these preferences. We did observe one occasion when a member of staff was speaking to a person about their interests and hobbies, but staff did not have time to do this consistently.

People told us that they were warm, comfortable and well fed and looked after, but that staff did not have much time to spend just talking with them. Some people spoke of a lack of conversation. People told us "Staff have no time really to chat" and "They chat as they're working usually." One member of staff told us "People's physical, personal care, dietary, nutritional needs are met. Good quality care is provided. There is little time to go much beyond this." We observed that some staff met people's needs and also spent time with them in a relaxed and unrushed manner. Other staff only spent time with people whilst assisting them with their personal care needs.

There were group activities organised, in which people could participate, such as arts and crafts, games, reading books and newspapers and watching films. People had the opportunity to see entertainers once a week. The local library provided books and items to support people to reminisce, which were changed once a month. The service had converted one room into a 'pub', which contained a small bar and seating area. Staff told us people enjoyed pub quizzes here and could relax and chat with a drink. Noticeboards displayed activities information and photographs of people participating in various events. One member of staff said that some people had visited a local theatre, had gone out for walks and that the garden was used for events in the summer months. Another told us that people did not have much opportunity to go out. During our inspection a member of staff who organised activities arranged a reading group and a quiz for people. People's differing needs became apparent as some people engaged with the activities, whilst others were not offered

Requires improvement

Is the service responsive?

the appropriate support to do so. Some people told us they enjoyed the activities, whilst others said there was little choice and they felt bored. One person told us "They used to be much better at occupying us…flower arranging died a death…there's not much to do."

Minutes of the most recent 'Residents and Relatives' Meeting in February 2015 showed discussion about people's activities. People enjoyed the event organised for Valentine's Day and visits from animal handlers. Some people felt there were less activities provided for people living with dementia and people who were unable to leave their bedroom. One member of staff who organised activities had not been trained in how to provide activities for people living with dementia. It was clear from talking with people, observation and looking at records that activities were provided at the service, but that these were not always sufficient or specific enough to meet people's differing needs or preferences.

We recommend that the registered manager seeks and follows advice and guidance from a reputable source, regarding the provision of meaningful activities which reduce the risk of social isolation. This should include people living with dementia and those who are not able to leave their bedrooms.

People told us that they could talk with staff or the registered manager if they had a complaint or a concern. A relative told us "If there is a problem, it is addressed straight away." People, relatives and staff were aware of the complaints procedure and how to use this. Complaints had been recorded and these showed that they had been investigated and responded to. For example, one visitor said that staff had breached their relative's confidentiality. This had been investigated at the service and referred to the provider.

Requires improvement

Is the service well-led?

Our findings

One person told us "I know the manager - everyone loves them. The place is managed well by the manager." Another person said "We have a lovely manager." Despite people's positive views, we found that improvements were required in relation to some aspects of the management of the service. One relative said "The home is reasonably well managed. There is a hierarchy of staff. I know the manager and where to find them."

The provider had a clear set of vision and values. The statement of purpose stated that the service aimed to support people's health and wellbeing, whilst respecting their dignity, privacy and independence. The service had a clear, accountable management and staffing structure. We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities both to people and to the management team. They knew who they were accountable to.

The service had a welcoming, pleasant and busy atmosphere. The registered manager told us that they aimed to nurture an open and positive culture that focussed on people. People told us the registered manager and staff were approachable and we observed that people were comfortable with them. One person told us that the registered manager was kind and had come to see them that morning, as they were upset. Relatives told us they felt that the home was well run and they could speak to the manager at any time if they had any questions or concerns. They described how the service kept them informed about any developments in their relative's health.

People, their relatives, members of staff and professionals associated with people's care were asked for their views and to make suggestions about how the service was run and the care people received. Quality assurance surveys were sent out to gain feedback about the quality of the service provided once a year. Completed surveys were evaluated and the results were used to inform improvements for the development of the service. The most recent analysis for returned surveys contained mostly positive responses. Some suggestions had been made about food, G.P.s, decoration and laundry and the registered manager had taken action in response to these suggestions. Suggestions were followed up with monthly reviews and feedback at the 'Resident and relatives' meetings. Professionals associated with people's care were also able to complete a 'Professional visitor's feedback form' at any time.

'Resident and relatives' meetings were held, which enabled the registered manager to keep people and their families up to date with the running of the service, and gave people an opportunity to express their views. The minutes from the most recent meeting in February 2015 showed discussion about various issues, including the use of laminate flooring or carpet, staffing levels and activities. The registered manager told us that they met with senior staff about people's suggestions and then fed back at the next meeting about any actions taken. People and their relatives said they were able to speak with the manager at any time.

Staff told us there was good communication with senior staff and the management team and they could discuss any concerns at any time. One member of staff said "The manager is very approachable". Staff meetings were held where information was shared about a variety of issues to improve the service provided for people.

Staff had access to the service's policies and procedures, which gave them guidance about a variety of issues, such as what to do if a person went missing, behaviour that challenged, end of life care and about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager was in the process of updating the policies and procedures but this had not been completed. Staff were aware of how to report abuse because the relevant contact details were available in information leaflets. However, the main policy and procedure for the service had not been reviewed since 2013 and did not include guidance about reporting to the local safeguarding authority. Staff were aware of how to reduce the risk to people from the spread of infection. There were several policies and procedures for staff to follow in relation to this, although some were dated 2010 and 2013 and some were general and not specific to the service. It was clear that although staff knew the correct procedures to follow, these policies and procedures did not provide staff with written up to date best practice guidelines, including any changes in legislation.

We recommend that the registered manager uses the most relevant reputable sources to update the policies and procedures to reflect best practice guidance and changes in legislation.

Requires improvement

Is the service well-led?

There were systems in place to review the quality of various aspects of the service provided, such as checking whether the service was safe, effective, caring, responsive and well-led. The management team carried out regular audits. For example, for risks associated with the environment, the spread of infection, fire safety and equipment used to assist people to move. Additional quality assurance checks were carried out by a senior manager within the organisation. A report was given to the registered manager, which identified areas of good practice and any shortfalls. Any shortfalls identified from audits or quality assurance surveys were added to an on-going action plan. These actions were then followed up to ensure they had been completed. together with any action taken and completed.

Improvement was required in the management of medicines and permanent staffing levels. The registered manager was aware of these shortfalls and had taken some steps to address these issues. They had introduced assessments and checks to make sure that staff were competent to administer medicines and that the appropriate records were completed. The registered manager was in the process of recruiting new staff and offered incentives for staff to remain at the service.

The registered manager notified the Care Quality Commission (CQC) of any significant events that affected people and deaths at the service. Records were labelled, dated and stored securely and confidentially in dedicated spaces.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines, corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met: People's health, safety and welfare was not always safeguarded by sufficient numbers of suitably qualified, skilled and experienced staff.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.