London Residential Healthcare Limited

Steep House Nursing Home

Inspection report

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Date of inspection visit:
04 July 2016
05 July 2016

Date of publication:
20 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 4th and 5th July 2016 and was unannounced. Steep House Nursing Home is registered to provide accommodation for up to 56 older people who require nursing or personal care. The accommodation is arranged over three floors and has a garden area. At the time of our inspection there were 52 people living at the home.

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

People were protected from the risk of abuse. The staff we spoke with demonstrated their understanding of how to safeguard people and report any safeguarding concerns. The provider ensured that safeguarding policies and procedures were in place and accessible to staff.

Risks affecting individuals had been identified, appropriately assessed and measures put in place to protect them from harm. People's risks assessments were regularly evaluated to ensure they remained current. Environmental risks were regularly reviewed and documented and personal evacuation plans were in place to ensure that people were kept safe in the event of an adverse incident such as a fire. Equipment and utilities were serviced regularly, and internal checks protected people and others from potential risks in the home.

The home was adequately staffed to meet people's care needs on the days of our inspection. Where shortfalls were identified, the registered manager sourced additional off duty staff to cover any shortages and ensure staffing levels were maintained. However some staff and relatives expressed concern that there were not always enough staff to manage if staff were away or off sick.

The provider had not in every case ensured that all the relevant recruitment checks were carried out for newly employed staff. This meant that people might not always be protected from the risk of the provider employing staff who were not suitable for their role.

The provider had appropriate arrangements in place for managing people's medicines safely. There were accurate records of medicines administration by nurses and topical creams administered by care staff and information to support the administration of medicines was available to staff. However, some improvements were required to ensure that medicines were always stored safely to ensure that risks to people were minimised.

New staff followed a period of induction which included the provider's mandatory training, followed by a period of working alongside more experienced staff, to ensure that they were competent to carry out their role. The registered manager held regular supervisions with staff and staff told us that they felt supported by

the registered manager and the head of care. Staff completed a range of training to develop the skills and knowledge they required to meet people's needs.

The provider followed appropriate procedures to ensure people's rights were upheld in line with the Mental Capacity Act (2005). Mental capacity assessments had been completed for people and people's consent to care and treatment had been sought accordingly. Best interest decisions were completed when people lacked the capacity to make their own decisions.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available to people throughout the day. For lunch a choice of freshly cooked meals was offered, with alternatives available. The chef was knowledgeable about people's individual requirements such as those people who required a soft diet or a diabetic diet.

People were supported to maintain good health through access to ongoing health support. Records showed that other healthcare professionals had been involved in people's care such as the dietician, diabetic nurse, occupational therapist, and referrals were made where appropriate.

People received care and support from staff that knew them well and were caring in their approach. Relatives described staff as kind and caring, friendly and welcoming. People were offered choices in their day to day decisions. The relationships between staff and people receiving support demonstrated dignity and respect.

The head of care knew each person and their needs well and acted in accordance with those needs to ensure that people received safe and effective care. Care plans contained some detailed and individual information around aspects of people's care, such as their nutrition needs and wound care. However information about some people's health conditions was not always complete and did not consistently provide staff with the information they might need to support the person effectively, for example around managing behaviour which challenges.

Activities were available for people to take part in and the activities programme was run by a committed activities leader. However activities were not always individualised and designed to stimulate people living with dementia. We have made a recommendation to support the provider to ensure that people's social needs are met.

A system was in place for people to raise their complaints and concerns and they were acted on.

Quality assurance systems had been put in place and were effectively operated to monitor aspects of the quality of service delivered for people. Audits identified shortfalls and actions plans were put in place to secure improvements. Relatives' and residents' views had been sought on the quality of the service.

The registered manager promoted an open and positive culture within the home. They were proactive in encouraging input from and engagement with staff, people and their relatives. Staff were supported to be clear about their roles and responsibilities through effective supervision, training and team meetings.

During this inspection we found two breaches of regulation. You can see what action we asked the provider to take at the back of the full version of this report.

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.

The provider had not ensured that all staff had completed the relevant pre-employment checks to ensure their suitability to work with people.

There were sufficient staff to support people on the days of the inspection. However staff and relatives gave mixed views on whether there were always enough staff deployed to meet people's needs. .

Some improvements were required to ensure that people were protected from the risk of unsafe storage of medicines.

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

Risks to people had been identified and actions were taken to ensure their safety.

Is the service effective?

Good

The service was effective

The provider followed appropriate procedures to ensure people's rights were upheld in accordance with the Mental Capacity Act (2005).

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

People enjoyed a varied and nutritious diet which reflected their preferences and dietary needs.

People were supported by staff to access health care services as required.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and compassionate. Staff took the time to support and involve relatives in people's care.

People were given choices and staff respected their wishes.

Staff upheld people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not consistently contain the level of information required by staff to ensure that people's needs would always be met.

Activities for people were not always individualised to take account of their interests, abilities or need for stimulation. Staff did not always ensure that people's social needs were met.

A system was in place for people and relatives to raise complaints and concerns and these were responded to.

Is the service well-led?

Good

The service was well led.

There was a positive and open culture within the home where feedback was actively sought and responded to by the provider. Staff and relatives of people using the service said they felt listened to.

The registered manager demonstrated good management and leadership. Staff were supported to understand their roles and responsibilities through an effective system of training, supervision and appraisal.

The provider actively monitored the quality of care and took appropriate actions where necessary to drive service improvements.

Steep House Nursing 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 4th and 5th July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, an inspection manager, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service; on this occasion they had experience of family members living with dementia who had received residential care. The expert by experience spoke with people using the service and their relatives.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We requested a Provider Information Return (PIR) and this was completed by the provider before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We spoke with two people living at the home, eight relatives, the registered manager, the head of care, the chef, an activities co-ordinator, three nurses and five care staff. We spoke to a further five relatives after the inspection and four health and social care professionals.

We reviewed records which included fourteen people's care plans and monitoring records related to people's care, people's medicine administration records, eleven staff recruitment records and records relating to the management of the service. These included; policies and procedures, quality assurance records, accident and incident reports and staffing rotas for the period of 12th June to 2nd July 2016.

This service was last inspected 11 December 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Recruitment checks, such as proof of identity, provision of suitable references and a Disclosure and Barring Service (DBS) check were in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider also checked nurses were registered with the Nursing and Midwifery Council (NMC) which confirmed their fitness to practice safely.

However, the provider had not completed all of the required pre-employment checks to ensure new staff employed were of suitable character and experience before starting their role. Three of the recruitment records we viewed did not fully document the applicants' full employment history, with an appropriate explanation of any gaps, or reasons why their previous employment had ended. In another record, only the years of employment were recorded and not the months, so it was not possible to establish if there had been any gaps in employment. This meant that the provider did not have all the information they needed to judge whether an applicant's employment history might indicate concerns about their previous work conduct or character that might put people at risk.

There was a risk that staff being employed by the provider may not be suitable for their role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that there were nine nurses and 45 care staff working at the home. Two nurses were on duty each morning, afternoon and night. During the week the head of care, who was also a registered nurse, was on duty from 8am to 5pm and provided leadership to the nursing team. There were 11 care staff on duty on the morning shift, nine on the afternoon shift and five on the night shift. The registered manager told us that the home used a staffing dependency tool to establish staffing needs and had over-recruited their nurses and carers by 10% to enable them to manage staff absences effectively. They confirmed that they no longer used any agency staff in the home, to help ensure consistency of care for people from regular staff who knew people well. The registered manager told us that they also covered any gaps in the rota by calling on off duty members of the staff team who lived on site. Staff members who were off duty let the registered manager know if they were available to cover shifts if needed. A care worker we spoke with confirmed this. A nurse told us that when she came to work at the home over a year ago they were short staffed and it was very stressful, but that staffing had got better.

We received mixed feedback from staff and people's relatives about whether there were enough staff. Some staff and most relatives we spoke to thought that on occasion the home felt short staffed, particularly if staff were off sick. Some relatives told us that staff responded very quickly to call bells during the day but not always at night. Another told us that their loved one sometimes had to wait to be supported to move as two staff were required to use the hoist. We saw from staff meeting minutes that staff had on occasion raised concerns about staffing pressures and around there being enough staff to meet people's needs, particularly if there were staff absences. We saw that the manager had responded to this by re-iterating that the home was well staffed and tried to explore what the issues were. They reminded staff of the need for teamwork across the floors and suggested different ways of working to better utilise staff time.

Systems and processes were in place for the ordering of medicines. At the beginning of the previous medicines cycle a number of people had not received their medicines as not all the medicines ordered had been received from the pharmacy. We found that appropriate action had been taken by the home including contacting the pharmacy to request urgent delivery and seeking medical advice from the GP. The registered manager told us during the inspection that they were in the process of changing pharmacies to help reduce the risk of medicines being missed.

Information about allergies, "how I like to take my medicines", "when required" and variable dose" medicines were held within each person's medicines administration record (MAR). The administration of medicines was recorded using the MARs. A care worker explained how they applied topical creams to people as part of their personal care. We viewed MARs for three people with a care worker. These records indicated the name of the product, when and where the topical creams were to be and had been applied to people. Topical creams were applied safely for people.

All medicines, including those requiring refrigeration, were kept within recommended temperature ranges. Most medicines were stored securely. However, unused medicines from the previous medicines cycle were not stored securely on the day of the inspection as they were due to be collected by the community pharmacy. This meant that medicines were left out for a period of time until collection rather than being locked away securely in a cupboard. We also noted that one person had a tin of thickening powder in their room. This is regularly used in care homes to thicken fluids for people who have difficulty in swallowing. However the powder itself is a choking risk and therefore should not be accessible to people in its powder form. Although there was no evidence of impact of people as a result of these incidents, improvements were required to ensure that people were protected from the risk of unsafe storage of medicines.

Risks to people had been clearly identified and addressed within their care plans. Risks had been assessed in relation to a number of areas such as falling, manual handling, malnutrition, pressure sores and behaviours. Staff were able to explain how they would manage risks to people in practice, for example, through the use of equipment to reduce the risk of falls and completing routine checks on people to make sure they were safe. We observed a morning staff shift handover which was attended by all staff on duty. Staff were updated on people's needs during the morning and evening handovers, which included areas of risk to people and anything else staff starting their shifts needed to be aware of to keep people safe.

We saw that people living at the home had Personal Emergency Evacuation Plans in place which were revised annually. These identified people's individual needs in order to highlight what support they required in the event they had to be evacuated from the home in the event of an emergency such as a fire. The home had risk management procedures in place relating to environmental risks. These included an annual external fire risk assessment and monthly tests of fire alarm and fire equipment to ensure that they remained in working order. The home had a gas safety certificate dated May 2016. We saw that equipment such as hoists and slings were serviced bi-annually and that both lifts in the home had been serviced in May 2016.

The home had accident and incident reporting protocols and procedures which staff followed and carried out regular audits of accidents and incidents. We reviewed an audit from January 2016 which showed there had been nine falls during that period. Records showed who had fallen, the date, time, if there had been any injury, the type of fall, whether they attended hospital, the treatment given and any other action taken. We saw that analysis had been undertaken which identified trends that the registered manager was able to take action on. For example, one person who had fallen twice during that period had been encouraged to use their call bell for assistance if they wanted to use the bathroom.

Staff we spoke with demonstrated their understanding of safeguarding and their responsibilities for reporting concerns. Records confirmed that staff had completed training in safeguarding and staff had access to policies and procedures for guidance should this be needed. People and relatives told us they felt able to raise any concerns they had. One relative said that the care provided was "pretty good on the whole" and told us that her relative was safe and well treated. Another told us "Mum is safe and happy and in the best place I can leave her and not have to worry about her 24/7."

We saw from records that safeguarding incidents had been appropriately reported, investigated and relevant actions to keep people safe had been taken. People were protected from the risk of abuse.

Good

Is the service effective?

Our findings

The provider had recently introduced the requirement for new staff joining the home to undertake the Care Certificate, the industry recognised standard induction, to ensure they could provide people's care effectively. A new member of the care staff team who had joined the home in February 2016 confirmed that they had received an induction and a period of job shadowing, which is a period of time spent observing and working closely with a more experienced staff member to learn on the job. They told us that they felt their induction had effectively prepared them to undertake their new role.

All staff were required to complete the provider's programme of mandatory training that included; manual handling, fire safety, safeguarding, the Mental Capacity Act (MCA) 2005, infection control, health and safety and first aid. Records showed that staff had completed this training. A relative told us "Staff know what they are doing; they seem to be trained pretty well."

Nurses completed other training relevant to people's healthcare needs such as catheterisation, wound care, syringe driver and tissue viability training. Staff were also currently undertaking the "Six Steps to Success" training programme to enable them to support people to have a more personalised and individual experience at the end of their lives. A healthcare professional told us "The manager organised training for staff in the interest of patients, and ensured that staff attended".

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs.

Staff told us they felt supported in their role and felt able to talk to the head of care or registered manager at any time. Records showed that staff had supervisions every other month with the registered manager. We saw copies of supervision notes which confirmed that supervisions covered reviews of work performance and agreed future targets as well as addressing any training and development needs for staff. The provider had produced a set of laminated reference cards for staff to carry with them whilst at work, to remind them of key information when looking after people, including the principles of the MCA, respecting people's dignity, recognising abuse and responding to emergency situations. People were cared for by staff who received support in their role.

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.

Records showed that the service had carried out mental capacity assessments for people living at the home in line with the local authority's best practice guidance. Where people were able to make decisions for themselves, their consent to care and treatment had been sought. We saw that accompanying decision-specific best interest decisions had been made for people when they lacked the capacity to agree to decisions involving their care, and that DoLS had been applied for where appropriate. Best interest assessments were carried out in consultation with relatives, friends, advocates and health and social care professionals and were subject to regular review. The provider ensured that people's rights were protected in accordance with legislation and guidance.

People and relatives told us that the food at the home was "lovely". The chef developed menus in line with people's preferences, ensuring home-made and nutritionally balanced meals were available every day. A board was displayed in the kitchen with people's photographs which showed people's individual dietary requirements such as those people who required a diabetic diet or people who required a pureed diet because of chewing or swallowing difficulties. Two main menu choices were usually on offer each day and people who didn't want either option could choose from regular alternatives such as jacket potatoes or omelettes.

Lunch was a social occasion with lots of staff members supporting and chatting to people and pleasant music being played in the background. We observed that the tables were attractively laid for lunch, and that people were offered beer, sherry or wine with lunch or soft drinks with their meals. Food was served by the chef from a heated food trolley. The lunch looked and smelt appetising and condiments were available for people to use. Most people ate independently.

One person told us "We get a good choice, they come around the day before and chef goes out of his way to help you". A relative said "Oh yes he loves his food here, at home he was very fussy with his food, but not here, he enjoys it". People had drinks available to them at all times. Tea and coffee were served to people every four hours and afternoon tea included homemade biscuits and cakes.

People's nutritional and fluid intakes were maintained and monitored. People at risk of losing weight were on fortified diets to increase the calorie and nutrient content of their food and people's weight was monitored monthly. One relative told us "My wife now has pureed food, she lost a lot of weight but now she's put it back on".

The registered manager explained that there had been concerns regarding access to GPs as a result of two practices merging in the local area. The registered manager had taken the required action to ensure people's access to healthcare was not impacted upon whilst the transition of people to the new practice was being completed.

People also had access to the optician, dentist and chiropodist. We saw from people's care plans that they had been referred appropriately to healthcare professionals when required, including the Speech and Language Therapist (SALT), dietician, diabetic nurse, tissue viability nurse and occupational therapist. People were supported to have access to the healthcare services they needed to maintain good health.

We saw that there was an effective programme of improvement to the environment in place. This included a recent redecoration of the main lounge and a planned refurbishment of a third lounge, along with plans for a new hairdressing salon.

Good

Is the service caring?

Our findings

People's relatives told us they were happy with the care provided to their loved ones. One person told us that their relative had been living at the home for just over six months. They said "So far I can't fault their care, it's absolutely delightful" and "Staff are endlessly cheerful". They went on to say that they were touched with how staff looked after people, "with caring and good humour". Other relatives described staff as "absolutely lovely" and that they got "a warmth" from staff. Relatives also spoke of the good relationships they had themselves developed with staff, telling us it "feels like you can really talk to the staff."

The home ran a key worker system where people were allocated certain members of staff who were directly responsible for their care. Key workers knew the people they were looking after well and were able to talk about what they knew about the person's history and what was important to them. Healthcare professionals we spoke to described staff as "caring and responsive to individual needs along with supporting relatives". A relative told us that staff spoke to people "nicely, kindly and respectfully" and that they have "always been quite impressed" with the care provided by staff.

We saw that people were offered choice in their day to day lives. People chose their meals the night before, however if they decided they did not want what they had previously ordered, they could change their mind and choose something different on the day. Staff described how they would offer choice to people who could not communicate by holding out clothes for them so that they could touch which they wanted to wear. A healthcare professional described that staff members "appeared very compassionate, and were aware of the need to offer patients choice. It was apparent that staff were compassionate as to patients' needs and wanting to accommodate these". One relative told us that their loved one had not been eating well. They described speaking to the chef about this who provided the next week's menu so that they could spend some time going through the meal options for the following week to support her to make the right choices. They told us "Nothing is too much trouble for them".

A person told us how staff protected their dignity when they were supported with personal care and said "They are kind and respectful towards me and they always knock on my door before they come into my room and always cover me up and have the door closed." Staff understood how to ensure people's privacy and dignity. One described how they would knock on the person's door, ask how they are, ask if it would be ok to give them a wash and if they were happy, would then do this by covering one part of their body whilst washing another. A member of staff described the importance of "making sure they [people] feel comfortable with us". A relative described how their loved one was "always nicely turned out, hair washed and brushed" when they came to visit.

One relative told us that her relative "hasn't looked back" since coming to live at Steep House. She described that her relative had "come out of herself" and told us "I've got my Mum back".

Requires Improvement

Is the service responsive?

Our findings

We saw some detailed and individual plans for people around certain areas of their care, for example, in relation to people's nutrition needs and skin integrity/wound care. However, we found that this level of detail was not consistent for all areas of the care plan.

One person's care plan prompted staff to encourage the person to drink plenty of fluids to reduce the risk of Urinary Tract Infections (UTIs), but did not include any detail of how staff might recognise if they had a UTI. For people with diabetes, although there was generic guidance on managing the condition in one of the home's policies, there was no indication in people' s care plans of what that person's normal blood glucose levels should be or what symptoms that person might show if their blood glucose levels became too low or too high. Although staff were able to deal appropriately with a person who had had an epileptic seizure at the home very recently, there was not always guidance for staff in care plans for people living with epilepsy on what signs staff should look out for, or what they should do, in the event of a seizure. There was a risk that a member of staff who might be unfamiliar with the person, or with the symptoms of epilepsy, might not recognise if a person became unwell or know how to respond appropriately. We noted that the provider's training plan did not include training on epilepsy. The registered manager confirmed that they had booked this training immediately after our inspection.

People's daily fluid intake was recorded and staff understood that daily fluid targets were based on the person's weight. However daily fluid charts and care plans contained no detail on what people's daily fluid targets should be so that staff would know if fluid intake was within the prescribed targets for that person to ensure that they were receiving enough fluids each day.

We also found that staff didn't always know how best to manage behaviours which challenge, which could sometimes be displayed by people living with dementia. Care plans often lacked detail on individualised interventions to help staff to effectively support people to manage these behaviours. One record we viewed just referred to standard phrases such as "take action when necessary", without detailing what that action might be for that particular person or when it might be deemed to be necessary. Another identified the requirement for staff to "provide support and reassurance" when the person became agitated, but with no detail on what that might entail.

Care plans were subject to regular review. However we could not always see any evaluation of the effectiveness of the care plan or any revisions made as a result of the review. There was a lack of evidence to demonstrate the outcome of the reviews of people's care plans. This meant that people were at risk of not receiving appropriate care and treatment to meet their changing needs.

One person was prescribed a "just in case medicine" and their care plans contained supporting actions, including summoning expert advice where appropriate. We reviewed the care plans and records for two people prescribed medicines that required blood monitoring. These records contained test results, subsequent scheduled tests and the exact dose to administer. However, additional escalation care plans were not available for five out of six people prescribed similar medicines. This meant that staff might not

always be able to recognise if a problem arose and what they should do, including when to seek further expert advice.

Care plans did not consistently provide staff with the information they might need to care for people effectively. The provider had not maintained an accurate and complete record in respect of the care provided to each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that people received a bath or shower according to their preferences and at least twice a week and in between times they would have a strip wash. However this was not always in keeping with what relatives told us or with the records we viewed. One relative told us that when their loved one lived at home they would have a bath every other day but since they had lived at Steep House they did not always have one every week. In one person's care plan, it was recorded that their preference was for a shower two to three times a week, however they had not been recorded as having one between the dates of 4th and 20th June 2016. Daily washes were recorded in between those dates, with the exception of five days. Some people's care plans did not specify what people's preferences regarding bathing, showering and washing were. We therefore could not be assured that people were always receiving a bath or a shower as regularly as they wanted one.

People and their relatives told us about the improvements they had made as a result of the care they received in the home. For example, a relative told us that their loved one had through their dementia experienced behaviour which challenged staff but they had become much calmer since living at the home. Another relative told us that their loved one had suffered from severe skin problems which were not healing in the community but had healed within the home "within a short space of time".

The home ran a programme of daily activities. These included arts and crafts, flower arranging, nail painting, singing, board games, skittles, and memory activities. We also saw that there were sometimes external visits, for example from the Birds of Prey Centre or the mobile library. There was a piano in one of the lounges that some people liked to play. Staff told us that people who did not leave their rooms had one-to-one activities in their rooms, including activities staff going in to see people to have a chat, helping them choose from menus and playing memory bingo. The home had a minibus and arranged outings for small groups of people a couple of times a week to visit the local shops or garden centre. The home had a 1950's style lounge to help people with their reminiscence. One relative described how staff had facilitated for some of her loved one's own possessions to be in the lounge.

We received consistently high praise from people's relatives for the home's lead activity co-ordinator, who they described "worked tirelessly" to improve people's experiences. For example, one relative described how her loved one did not like leaving her room, so the activities co-ordinator brought art in to sit with the person in their room to try and get them interested in it. As a result the two had really bonded. Another relative described the activities co-ordinator as "really excellent at what she does". They described how she talked to their loved on in their room, sitting and reading to them, massaging his hands and putting music on for them.

However, activities were not as individual and personalised to the needs of people living with dementia as required. They did not always take account of people's interests or promote their skills or keep them interested and engaged for a reasonable period of time without becoming distracted. A relative described how their loved one had taken part in a small cookery class with which they really engaged and enjoyed. However these types of activities were not consistently on offer for all people.

The home ran an Oomph programme, which is a programme designed to improve the wellbeing of older people through mental stimulation and physical exercise. Staff told us that people enjoyed this. However this programme was only run twice a week. There was scope for improved opportunities for this or other types of stimulation for those that were able, to keep people mentally and physically active.

We observed during our inspection that staff did not often have time to sit and engage with people either in their rooms or in the communal areas. As a result we saw that people often sat in the lounges for long periods without the opportunity to communicate with people or engage with anything to occupy their minds. While the activities co-ordinators did their best to spend time with people in their rooms, these people spent long periods on their own with nothing to do and were at risk of social isolation. Some relatives told us they would like to see their loved ones more active and stimulated.

We recommend that the provider seeks guidance from a reputable source on how to make activities more stimulating and more individualised to the needs of people living with dementia and to reduce the risk of social isolation.

The provider had a feedback, concerns and complaints procedure which was prominently displayed in the home and included an escalation process if people weren't satisfied with the outcome of their complaint. We reviewed nine complaints received since June 2015. We saw that the registered manager had responded to and investigated complaints raised appropriately. A relative told us that the registered manager "always sorts everything out" and described a time when they had made a complaint which was dealt with and they never had to raise it again. An effective system was in place for people to raise their complaints and concerns and ensure they were acted on.

Good

Is the service well-led?

Our findings

There was a positive and open culture within the home. Staff said they felt able to raise concerns, and were confident they would be responded to. The registered manager took pride in being accessible and supportive to her staff team and was well liked by them. One member of staff told us "She is very welcoming, I can see her anytime". Staff and relatives described the registered manager as "very approachable" and "never too busy to see you". The head of care for the home was also a capable and knowledgeable leader of the nursing team, with relatives describing her as "very calm, kind and caring". Staff also spoke of being able to refer any of their concerns to the head of care. We saw during inspection that the service was effectively run between the manager and the head of care. Relatives described the home has being "run well, without being regimented" and told us "it seems a smoothly run ship."

The manager was passionate about the home and proud of the improvements she had put in place since becoming manager. One member of staff described the impact of recent improvements at the home; "better staff, better management, better communication. A better team now than it was a year ago. I feel very happy with this home at the moment".

The registered manager encouraged the involvement of people and their relatives in the running of the home and valued their input by holding regular meetings and making herself available in between times. We saw from meeting minutes that relatives felt able to ask questions and raise concerns and that the registered manager used the meeting as an opportunity to receive feedback, keep relatives up to date with developments and to exchange ideas. People told us that they could talk to the manager whenever they wanted to. One said "Yes I can talk to the manager and if you send for her she's up here like a shot and yes I think she does a good job".

The registered manager described how feedback and comments from people and their relatives had influenced how the service was run. For example, the registered manager had reviewed the arrangements for deployment of staff across all parts of the home to ensure that all staff were better placed to meet people's needs.

Regular staff meetings were held. We saw from the minutes that staff were reminded about important aspects of care such as keeping care plans up to date, ensuring the effective use of daily notes, and ensuring that staff were present in the lounges at all times. We noted from the minutes of a staff meeting that the registered manager had reminded staff to ensure that they spoke in English at all times around people. We saw that some staff were enrolled on English courses to help improve their English language skills course so that they could communicate more effectively with the people they cared for.

The registered manager explained that she encouraged feedback and constructive challenge from staff through staff meetings and supervision. She advised that there was no provision for a staff survey in place at the moment but this was something the provider was planning, in order to provide a further opportunity for learning and improvement.

The manager demonstrated good management and leadership. She ensured she was visible 'on the floor' on a daily basis. Effective policies and management arrangements were in place. This meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. Policies included safeguarding, whistleblowing and complaints. The provider had in place a 'Philosophy of Care' which included core values based on a 'residents charter of rights' which was demonstrated in the care provided and feedback from people's relatives. A health and social care professional told us that the registered manager "appeared to be positive, showed initiative and acted on suggestions".

A system of monthly audits provided a framework to support the home in monitoring and improving the quality of the service provided. Audits were carried out by the registered manager, the head of care, the heads of each department, or the area manager. The registered manager was responsible for overseeing the completion of the audits and the actions arising from them.

We viewed audit records from January to June 2016 and saw that monthly audits had taken place across a number of areas including infection control, environment, catering, medication, accidents and incidents, and weight and nutrition. We saw actions being taken as a result of audits which included discussions and supervisions with staff and the creation of action plans to address areas identified as requiring improvement. For example, in the environment audit, it was identified on 25 January that most of the armchairs in one of the lounges needed washing or steam cleaning. We saw that this work was completed on 31 January. We viewed action plans which included the date the action was raised, the target date for completion and the date of completion and sign off.

The home had received a poor environmental health inspection in July 2015. We saw that there had been an urgent meeting to discuss this with staff the following day. An action plan was put in place to respond to all of the areas of concern raised by the report, and we saw that all actions were completed during October, November and December 2015. Regular environment audits have since been put in place to ensure that improvements were maintained.

A weight and nutrition audit in March analysed people patterns of weight loss or gain over the previous six months. Where it had been identified that there had been weight loss or gain, the reason for this was noted, and what actions had been taken to support people – for example, providing fortified drinks, nutrition supplements or referral to the diabetic clinic. In the April 2016 catering audit, we saw that all the staff had received the training that had been identified as necessary in the January 2016 catering audit.

Regular audits were in place with evidence that action was being taken to address any identified areas of concern. The manager told us, and we saw from records, that residents and relatives' surveys showed an improving picture of satisfaction with the care provided at the home over this period.

In addition, the provider's operation support manager carried out area assessment and monitoring visits at the home, which included observations, and speaking with people, visitors and staff to get feedback. We viewed the records of the provider audit from April 2016 and saw that it looked at staffing, safeguarding concerns, personnel files, supervisions and appraisals, training, medication audits, environment check and complaints.

Monitoring systems were in place to ensure that people received high quality care and that improvements were identified and implemented.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 17 HSCA RA Regulations 2014 Good governance The provider had not maintained an accurate and complete record in respect of the care provided to each person. This was a breach of Regulation 17(1)(2)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not operated effective recruitment procedures to ensure that persons employed were of good character. The provider had not protected people by ensuring that the information specified in Schedule 3 in relation to each person employed was available. This was a breach of Regulation 19(1)(a)(2)(a)(3)(a).