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Whitfield

Inspection report

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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 carried out on 11 and 13 August 2015 and was unannounced.

Whitfield is a large detached residence, which is registered to provide accommodation and care for 30 older people living with dementia. Accommodation is set over two floors. There is a lift to assist people to get to the first floor. Bedrooms are situated on the ground and first floor and there are separate communal areas. It is located in the village of Whitfield and set back from the main road that runs through the village. At the time of inspection there were 26 people living in the service.

The service had a registered manager who was present on both days of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

Some people could become unsettled later in the day and staff were aware this happened. When staff identified an incident, they were able to resolve any situations. Staff knew how to support people if they became upset or agitated, but did not always record these incidents to monitor and review these in order to help prevent the potential for reoccurrence.

People were weighed on a regular basis. Some people had lost weight and had not always been referred to a dietician or other health care professional when this happened. However, actions were taken when weight loss was identified at inspection.

The risk of falls were not always managed safely to protect people from falling again. One person had not been referred to a healthcare professional such as the falls clinic staff. Other people had been referred, but were still at risk of falls. Accidents and falls were not looked at in detail to identify patterns or trends which could help prevent or reduce the likelihood of further accidents.

Medicines were not always managed safely; some medicines were not stored safely or dated to make sure they were safe to use. Safe systems were not in place for 'as and when' medicines to make sure these medicines did not have any adverse effects on prescribed medicines. Some checks that staff completed had not identified these shortfalls. Systems to keep the environment clean were not robust. Cleaning routines and checks completed did not include equipment such as commodes; which were unclean.

People were assessed before they moved in, although some of these assessments lacked detail. Care plans had not always been updated to ensure that staff were given information about people's current needs. However, staff knew each person well and how to support the person.

Most people's relatives felt they were kept informed about any changes in the needs of their loved ones. Although one relative did not know about a referral to a health care professional which would have helped to reduce any concerns they had about the health of their family member.

People were supported to make choices and be involved in their care. People's relatives were involved and included. People's preferences such as their likes and dislikes were considered when the care was planned to ensure staff knew and understood them. Staff treated people with dignity and respect.

Staff understood the principles of the Mental Capacity Act (MCA) 2005, although these were not always followed. Some people's assessments were not carried out in accordance with the MCA code of practice.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Applications had been made to the proper authorities to ensure that people were not deprived of their liberty unlawfully. Recommendations made by these authorities were followed to support people to live without unnecessary restrictions.

Activities were limited because the activity coordinator only worked part time. Care staff supported people to do things they enjoyed and outside entertainers, such as singers, visited the service.

People were offered and received a healthy and balanced diet. There were a range of different meals to choose from and everyone we spoke with told us they liked the food.

There were enough staff available to provide safe and effective care to people. Staff had time to engage with people and to respond to calls for assistance. Recruitment procedures were effective and new members of staff were assessed to be safe to work with people. Staff had received the training they needed to support people. Shortfalls in staff's moving and handling training had been recognised and further training and competency checks were being completed.

Staff were aware of their roles and responsibilities. Staff told us people were 'the heart of the service'. Staff we spoke with told us that people who lived at the service were 'the most important part of everything we do'.

There were systems and processes in operation to support people and their relatives to make a complaint or raise concerns. Complaints were acted on and responded to within the provider's timescales. People's relatives told us they, 'felt confident' to speak with the registered manager at 'any time'.

Summary of findings

People's views were sought through questionnaires and conversations with staff. Staff responded when people made specific requests. People's relatives felt that the registered manager and staff were supportive and listened to what they had to say.

People were protected from the risk of abuse. Staff knew how to keep people safe and who to report any concerns to. There was an open and transparent culture where staff felt able to have a say and raise any concerns if they felt they had to.

Individual emergency evacuation plans had been produced and staff knew how to keep people safe if they had to use emergency procedures.

The registered manager led the service well, so people, their relatives and staff were confident in the way the service was managed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some risks were not always managed to ensure people were kept safe at all times. People were not always referred to an external professional when there were changes in people's weight or when people were at risk of falls. Actions were taken when these were identified at inspection.

Medicines were not always managed safely as some medicines were not stored correctly and medicine administration records were not always completed properly.

The environment was not always kept clean.

People felt safe and relatives told us they were confident their loved ones were safe and that staff protected people.

Staff were recruited safely. There was enough staff on duty to make sure people received the care and support they needed at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff knew about the importance of making sure people gave their consent to their care and treatment, but did not always follow the principles of the Mental Capacity Act code of practice. Deprivation of Liberty safeguards were applied for so people were not restricted of their liberties unlawfully.

Staff received the training and supervision they needed to provide effective care. Shortfalls in training had been identified and training had been planned.

People enjoyed their meals and were given a range of choices that met their likes and dislikes.

People were supported with their health care to ensure their needs were met.

Is the service caring?

Good

The service was caring.

People were supported in a kind, friendly and caring manner by staff who understood their needs.

People were cared for by staff who respected their privacy and dignity.

Staff listened to what people had to say and respected their choices. People were given the opportunity to have a say about how their care was provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People's needs were assessed when they moved into the service, although some assessments lacked detailed information about the person. People had individual care plans, although some had less detail than others. However, staff knew and understood how to support people.

People had some opportunities to take part in activities; there were plans in place to develop activities further.

There was an accessible complaints procedure and people were confident that any concerns would be acted on and resolved.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Quality assurance systems did not always identify shortfalls in the quality of the service. Some records were not up to date or had not been reviewed to make sure changes in need were acted on.

Staff were given the support they needed to perform their role and understood their responsibilities. There was a family type atmosphere at the service.

People and their relatives knew who the manager was and felt that comments were listened to and acted on.

There was a registered manager in post who understood her responsibilities.

Whitfield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 11 and 13 August 2015 and was unannounced. The inspection team consisted of three inspectors.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned when we requested it and gave us detailed information about the provider's view of the service. Before the visit we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We looked at information received from social care professionals.

During our inspection we spoke with three people who used the service. Some people could not tell us about their experiences, so 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 spoke with six people's relatives, eight members of staff, including the activities coordinator and the cook. We also spoke with the registered manager and a senior manager for the organisation.

We observed how staff supported and spoke with people. We observed the lunchtime meal and observed how people spent their day. We looked around the service including shared facilities and in people's bedrooms with their permission. We looked at a range of records including the care plans and monitoring records for six people, medicine administration records, staff records for recruitment and training, accident and incident records, records for monitoring the quality of the service provided including audits, complaints records and staff, relatives and resident meeting minutes.

The last inspection was carried out in August 2013. There were no concerns identified during this inspection.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us they felt their loved ones were safe and that there were, "Sufficient staff to help people". People said that they felt safe; one person told us that they could speak to staff about anything that was troubling them. Relatives said that people were supported with their medicines and that staff, "Always check if residents have any pain".

During the inspection people were generally calm and settled but we observed two occasions when people used bad language and shouted at each other. These incidents did not escalate into anything more serious and people were not put at risk of harm. However, staff accepted this as part of people's conditions and told us this often happened later in the day. Staff resolved one situation quickly but did not recognise the second situation had the potential to develop and potentially put people at the risk of harm. Staff told us that this 'sometimes happened, particularly late in the afternoon.' Individual care plans showed that some people could become agitated and staff had sometimes made a record of this in the daily notes about people's care. Staff lacked understanding about recording incidents between people so were not able to monitor any patterns or changes in people's behaviour, to reduce the risk of it happening again. Monitoring these types of incidents helps to identify any patterns or trends, for example, the time or day or place the incident occurred, which could help to prevent future incidents.

Some people had lost weight and others were at risk of losing weight. Systems were in place to monitor people's weight, but when weight loss was identified effective action was not always taken. Some people had been referred to the dietician; referrals for other people who had lost weight had not been made. One person had been weighed on a regular basis, their nutritional needs for eating and drinking had been assessed and the records stated the person was 'eating well'. However, they had lost just over five kilograms, approximately 11 pounds, in six months. A referral had not been made to the dietician to seek support for the person. Their GP had not been contacted to make sure there were no underlying health problems which could have contributed to their weight loss. We noted that three other people had also lost weight and referrals had not been made for them either. The registered manager told us that a referral should be made to the dietician if any one person lost more than one kilogram in weight. She did not know why referrals had not been made. Arrangements were made for a review of people's weights and referrals were made to either the dietician or GP before we finished our inspection.

One person had been referred to the dietician, because they had lost weight, who had advised adding butter, cream and full fat milk to the person's meals and offering them full fat milky drinks. Although, meals were prepared with additional butter and cream as a matter of routine, staff were unaware of the specific advice given to support this person to have a fortified diet. They were at risk of not being offered the food and drinks they needed. The person's care plan had not been updated to include the advice of the dietician and there was a risk that the staff would not provide the care the person needed to keep them healthy leaving them at risk of further weight loss.

One person had fallen on a number of occasions but had not been referred to a health professional, such as the falls clinic staff, to obtain the support they needed and investigate why they were falling. The registered manager told us that referrals were made when people were identified as being at risk of falls, but they were still in the process of assessing the risk to the person. Arrangements were made to refer the person at the time of our inspection. Other people had been referred for professional advice and mobility aids had been obtained; but were not used consistently to keep people safe and they had fallen again. Staff said that the aids sometimes made people more prone to falling because it was more of a risk when they used the aid. This information had not been fed back to health care professionals who prescribed the aids so alternative action could be considered. However, a referral had been made to the GP to request a review of medicines in case this was a contributing factor.

The provider had not monitored all of the risks to people's health and safety and failed to mitigate any such risks. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Care plans contained a range of other assessments about risks to people and how these should be reduced and managed. For example; one person's care plan gave detailed guidance to staff about how to look after the person's skin with the use of pressure relieving equipment,

including special cushions. Another person had been assessed as at high risk of urine infections and staff made sure this person had enough to drink to reduce the possibility of them being at risk of infections.

Medicines and prescribed creams were not always stored safely. Some prescribed creams and sprays, were left in bedrooms so were accessible to everyone. There was a cream in one person's bedroom which did not belong to them and had a different person's name on the label and so had been prescribed for another person. There was a risk that these creams and sprays may be used inappropriately by people. Information was not available to staff on medicine administration record (MAR) charts and dispensing labels did not show to which parts of the body the creams should be applied. Guidance was not provided to staff in people's care plans. We asked staff how they knew where to administer creams and sprays; they told us that instructions had been given by District Nurses when the items were first prescribed. This information had not been included in people's care plans so there was a risk that creams and sprays would be applied incorrectly.

There were a number of gaps on MAR charts where staff had not signed to say if medicines or creams had been administered or not. In some cases we found that the medicine had been given but staff had not signed the MAR charts. In other instances, it was not possible to tell whether the medicines had been administered so people may not always have received their medicines when they were supposed to.

The MAR charts showed when people had refused to take their medicines. One person had refused some of their medicines for several months. Staff had contacted the person's GP about this in May 2015. The medicine had been prescribed in a liquid form to help the person swallow their medicine more easily. The person had continued to decline one of the doses each day for several weeks prior to the inspection. Staff had not taken further action to make sure the person was not at risk because of this. Staff took action to obtain support for the person on day one of our inspection visit.

The dates that bottled medicines and eye drops had been opened had not been recorded. There was a risk that people were receiving medicines that was less effective and out of date. Medicines were not always stored as directed by the manufacturer to make sure that they were effective. One person had been prescribed a treatment which needed to be kept in the fridge; however, this was stored in the medicines trolley and was not kept cold.

Some medicines were stored in a special fridge and the temperature had been monitored daily. Records showed a number of occasions when the temperature rose above the maximum acceptable levels. Staff had not taken action to make sure the medicines remained safe and effective by being stored at the correct temperature.

There was not always guidance in place for staff about giving people 'as and when needed' medicines (PRN), such as pain relief. People were given pain relief when they needed it but there was no information for staff, in many cases, about why the medicine had been prescribed, any other medicines which might react badly with it, and the circumstances in which the person might need to be provided with the medicine.

Some handwritten instructions on MAR charts were incomplete. For example, when a form of pain relief had been prescribed, staff had not transferred warning information from the dispensing label about interactions with other forms of pain relief. Staff did not always have enough information about people's medicines to keep them safe.

The provider had not consistently managed medicines in such a way as to keep people safe. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Medicines were administered by trained, senior staff who were aware of the service's policy for medicines. We observed staff administering medicines to people safely during a medicines round and heard them asking people if they needed any pain relief. There were arrangements in place for a local pharmacy to collect medicines for disposal on a daily basis.

People and their relatives we spoke with said they had "no concerns" about the cleanliness of the service. The environment was generally clean and tidy but the service did not have adequate systems in place to ensure that routine deep-cleaning took place. Some of the commode chairs were stained and unhygienic. There was a smell of urine in some areas of the service and commodes which had not been emptied after use may have contributed to this. Toilet brushes were soiled in several instances. In

Is the service safe?

some bedrooms divan bases were heavily stained and mattresses, placed on bedroom floors to prevent people from hurting themselves, if they fell out of bed, were stained.

The design of the laundry room made it difficult for staff to maintain separate dirty and clean areas. For example, we saw that soiled clothing was being rinsed off in the sink which was directly adjacent to clean laundry so had the potential to become contaminated.

The lack of effective cleaning systems meant the premises were not always kept clean. This was a breach of Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Protective equipment such as disposable gloves and aprons were available in the service and we observed staff using them appropriately. Staff had received training in the prevention and control of infection.

Individual plans were in place to evacuate people in the case of an emergency and staff were able to accurately describe the process and identify fire exits. Regular fire alarm tests and drills had been carried out. Staff had received training in fire safety and told us that they had the opportunity to practice with emergency equipment so they knew how to use it. The service had a written strategy for dealing with other unforeseen emergencies in order to provide people with safe and continuous care.

Equipment including hoists, chair scales and the passenger lift were serviced regularly. Weekly maintenance checks had been completed and included water temperatures, window restrictors and bed rails. The testing of these areas, plus gas safety and wiring checks were up to date and had been carried out regularly to ensure the safety of the service's premises and equipment. A maintenance man was employed by the service and staff reported that any running repairs had been attended to promptly.

People and their relatives said that they felt there were enough staff working in the home. One relative commented "You could always have more staff, but they manage really well here and everyone is looked after". Staff told us that it was a busy working environment but told us they had time to support people.

There were enough staff on duty to meet people's needs. Staff were present in the main communal areas at all times. Staff responded to people when they asked for support or assistance. There were four care staff on duty during the day and two care staff at night. Staffing levels were assessed using a dependency assessment tool. A dependency assessment tool makes sure that staffing levels are assessed according to people's needs. The registered manager explained that staffing levels took into account the layout of the building and were flexible as extra staff could be brought in if additional support was needed, such as supporting people to attend appointments. Agency staff were not used and the rotas showed that staffing levels were consistent and the number of staff on duty met the assessed number of staff needed to meet people's needs.

There were systems in place to recruit new staff. Appropriate checks were carried out including obtaining a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. References were obtained and checks were carried out on people's employment history to make sure there were no unexplained gaps.

There were disciplinary procedures in place and the registered manager had taken action when the capability of staff was in question.

Staff were able to describe the different forms of abuse and knew what signs might indicate that abuse was happening. Staff knew who to report any concerns to and told us they felt confident any concerns would be acted on. Staff had received training on keeping people safe. They told us that if they reported any concerns they were acted on immediately.

The registered manager knew and understood their responsibilities about keeping people safe and free from the risk of abuse. If they were concerned about the safety of anyone using the service they contacted the local authority who were responsible for carrying out any investigations.

Requires Improvement

Is the service effective?

Our findings

People's relatives thought staff were supportive and looked after their family members well. They told us, "They (the staff) know what they are doing" and, "It is not just one or two carers here who are good. It is the whole lot of them". People we spoke with said they 'liked' the staff.

Most people were not able to tell us about their experiences, so we spent time observing how staff supported people. Staff communicated effectively with people in a way that suited them best and gave them time to respond. They listened to what people had to say and responded to requests for assistance. Relatives who felt their loved ones could not communicate well told us, "Staff really know how to talk to everyone". One person's relative told us, "(My relative) always responds to staff and that is really good".

The Mental Capacity Act (MCA) 2005 is legislation that sets out how to support people who do not have capacity to make a specific decision and protects people's rights. The MCA states that capacity must be presumed unless proven otherwise and that those assessments should be time and decision specific. People's capacity had been assessed when they moved into the service. However, these assessments had not always been reviewed since people moved in even though capacity to consent can fluctuate and change for people living with dementia.

Staff asked people for their consent when supporting them and staff understood about supporting people to make decisions. However, staff did not always follow the principles of the MCA. Some people had stated that they wished to have their bedroom doors left open at night. Bedroom doors were routinely shut to prevent people going into other people's rooms uninvited. This was done for reasons of safety, but people had not been fully involved in the decision to have their bedroom doors kept closed, the decision had been made for them. Staff had not explored ways to prevent people entering other rooms uninvited so that people could have their doors open. Some people needed to have rails on their beds to protect them from falling out of bed. Detailed risk assessments had been carried out but it had not always been recorded if the person had agreed that this was in their best interests. A best interest decision was needed, as some people lacked capacity.

The provider did not have proper procedures in place to obtain consent from the relevant person for care and treatment. This was a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people had made advanced decisions, such as Do Not Attempt to Resuscitate, this was documented and kept at the front of people's care plans so that staff could ensure that the person's wishes would be acted on.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. When people moved into the service a check was carried out to look at whether they were being restricted of their liberty. For example, that they would not be free to leave the service when they wanted to and would be subject to continuous supervision.

Applications had been made to the appropriate authority for people who had been assessed as being at risk of being deprived of their liberty. Some applications were in progress and other applications had been authorised. The registered manager was aware that these authorisations included recommendations as part of the authorisation. These recommendations had been acted on and incorporated into the care plans. For example, one of the recommendations from the DoLS authority stated that a review of the person's medicines should be carried out and this had happened. Another recommendation stated that the mental health team should be involved to help develop the person's care plan and this had taken place.

One person's relative told us how they had been involved in a DoLS assessment for their family member. The relative told us they had been invited to a meeting to discuss the implications of DoLS and said, "This gave us a much better understanding of what is involved".

Staff had received training in a range of subjects that helped them to carry out their role. Staff had completed training in areas such as safeguarding, health and safety, food hygiene, the Mental Capacity Act (2005) and Deprivation of Liberty (DoLS) safeguards, dementia awareness and managing challenging behaviour to help them understand and support people. Staff had completed

Is the service effective?

a workbook and a test to show that they understood the theory of how to move people but had not received practical training in moving and handling people safely. Some people needed support from staff to help them get in and out of bed, wheelchairs and chairs. Other people needed help with the use of specialist equipment, such as hoists. To ensure this was carried out safely, staff needed to be trained in the practical use of any equipment and moving and handling procedures by a suitably competent person. The deputy manager was a trained trainer in moving and handling and a practical training course had been arranged for staff but had not yet taken place. Staff had had their competency checked to make sure they could use equipment safely; however, some staff had been shown how to use equipment by another member of staff who had not been trained in how to use this equipment. We discussed this with the registered manager who made arrangements for the trained trainer to check staff competencies to make sure people were moved safely while they were waiting to attend the moving and handling training.

New members of staff completed an induction when they began working at the service. This was based on the new care certificate developed by Skills for Care (which is an organisation that gives guidance on standards of training that staff working in adult social care need). Staff also completed an 'in-house' induction, which was a competency based programme to make sure they developed the skills and knowledge to care for people. New members of staff shadowed more experienced members of staff when they first started work so they could get to know people and learn about people's individual needs.

Staff received regular supervisions and annual appraisals. This gave staff the opportunity to discuss their training needs, any concerns and receive feedback on their work. Staff told us they were supported and felt appreciated by the registered manager. They said they could approach the registered manager at any time if they felt they needed extra support.

People enjoyed their meals. One person who had just eaten their lunch said, "That was really nice" and another person told us, "The food is good". Another person remarked that they always had several choices at mealtimes and they, "Thoroughly enjoyed" the food. Relatives told us that the meals always looked appetising and they felt their loved ones were given the meals they liked.

People could sit where they wanted to eat their meals. Some people ate at the dining tables and other people preferred to use a small lap table. People were offered choices and if they did not eat their meal or told staff that they did not want it, staff offered them alternatives. One person was unwell and didn't eat their lunch, staff tried to encourage the person to eat their meal but they said they did not want it. Staff brought out a small plate of sandwiches, as an alternative and gently encouraged the person to eat some. Some people had always enjoyed 'ready meals' (which are pre-prepared meals available from shops), when they lived at home. A range of these meals were available so people could still eat them if they wanted to.

People who needed support and encouragement with their food and drink were given the help they needed. Drinks were available for people throughout the day and people could choose from hot and cold drinks. Snacks were offered during the morning and afternoon. Meals were freshly prepared and well presented. The cook knew how to prepare meals to ensure they met different people's needs such as catering for people with diabetes. Some people needed their meals served at a different consistency, such as pureed, to help with swallowing problems, and these meals were presented in individual portions so people could enjoy the tastes of the different foods.

District nurses visited people regularly and their advice was acted on. People were supported to see the dentist, chiropodist and optician for regular check-ups. Some people's conditions affected their mental health and advice and support was obtained from the mental health team to help support people. One relative told us, "Mum sees the chiropodist and optician regularly and the doctor when she needs to. I have no worries about her health". Some people needed support to maintain healthy skin. Equipment was in place, such as specialist mattresses or cushions for chairs to help reduce the likelihood of people developing a pressure sore. Staff made sure that people who stayed in bed were helped to change their position regularly to reduce the risk of a person developing sore skin.

Good

Is the service caring?

Our findings

People's relatives were positive about the staff. They said, "I consider it excellent here; the staff are very welcoming and capable" and, "They are really nice staff here who care about people". Relatives told us that a 'family atmosphere' was promoted. Relatives also told us that staff 'cared' about them as well and they considered this important as it made them feel welcome and gave them confidence in the staff. Staff were thoughtful and caring when speaking with people. During the two days of the inspection we saw kind and respectful interactions between staff and people. One person told us, "I couldn't ask for better than here".

People and their relatives were encouraged to share information about people's life histories, their preferences, likes and dislikes. This helped staff to get to know people. Each person had a 'Map of Life' in place which showed important information about people's lives, their relationships and what they did and did not like. One person's relative told us, "I have been asked about (my relative's) life history and have brought in photos and things so staff can use these in a memory box". Another person's relative commented that they had been asked to help fill out a 'This is me' booklet to help staff to get to know the person. Information about people's lives is important because people living with dementia may want to talk about historical rather than more recent events and staff should be aware about things that have affected people's lives. Some care files contained more information than others, however, staff were very knowledgeable about people and were able to tell us how people should be supported and what people enjoyed.

People had been asked about their personal care choices and their answers were recorded in their care plans. People and their relatives had opportunity to be involved in how their care was planned and given. Staff knew what people's preferences were and took this into account when supporting people.

Most people had families to support them when they needed to make complex decisions, such as coming to live at the service or to attend health care appointments. Some people did not have close family support and information about advocates was provided. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. People had support from advocates if and when they needed it. Some people had a lasting power of attorney in place and the registered manager was aware of which people's relatives had the authority to make decisions on the person's behalf.

People were supported to maintain their independence as far as they were able. One person liked to make their own hot drinks and was supported to do this safely. We asked the person how they felt about being able to do some things for themselves and they smiled broadly and gave us the 'thumbs up' sign. Some people liked to carry out tasks such as helping staff with the tea trolley and helping to set the tables for lunch. Staff encouraged and supported people to do this. Supporting people to maintain their independence was important because it helped people maintain and improve their well-being.

Staff listened to what people had to say and gave them support when they needed or asked for it. One person had lost a personal item; staff reassured the person and took time to help them find their possession. Another person asked staff questions about different things and each time staff answered patiently and reassured the person about their concerns. There was a lot of laughter during our inspection, staff joked with people and had a 'ready' smile when they spoke with people. People responded to staff and were relaxed in their company. Staff spoke clearly and slowly with people in a way they understood.

People's privacy and dignity was respected. People's relatives said, "Mum is treated with dignity and respect" and "Staff are so respectful and they really understand people". Staff were mindful of people's privacy and people were helped to the toilet discreetly and without fuss. Staff understood the importance of making sure that people were not put in situations where their privacy and dignity could be compromised. For example, there were times when people needed support with a hoist while they were in the lounge. Staff arranged for a privacy screen to be placed around them so other people could not see them being moved. The dentist visited on one of the days of the inspection to see a person. The person did not want to go to their room. They were happy to go to a quieter lounge and staff made sure the privacy screen was in place so the person could meet the dentist in private. Staff told us how

Good

Is the service caring?

they made sure people's privacy was respected. Staff said, "I always make sure doors are shut when we help with personal care", "We always knock on doors" and "Dignity is important".

The service had a 'Facebook' page and there was a policy in place for the use of social media sites. The registered manager said that most people had not been involved with these types of websites and did not know what they were. They told us that because of this, the policy meant there were no photographs of people placed on social media sites and it was only used to promote events. The website was monitored by the quality assurance person for the organisation to ensure that only appropriate content was placed on it, so people's privacy was protected.

People's religious, ethnic and cultural needs were taken into account when providing their care. Representatives from local churches visited people who wanted to meet them. Some people received Communion and this was carried out in private. Other people were supported by staff to attend church services.

People's families and friends were encouraged to visit and welcomed at any time. People's relatives told us they could 'call in', whenever they wanted. Some relatives told us they visited on a daily basis and said, "Staff are always welcoming. We never feel in the way". There were times when the service was very busy with relatives arriving to visit or to take people out. Staff welcomed relatives and escorted them to where their family member was. Staff made sure people were ready when families arrived to take them out.

As a residential service, end of life care was not routinely provided to people, but staff worked with health care professionals to make sure people received the support they needed to enable them to remain at the service for as long as possible. The values of the service were to provide a permanent 'home' for people, so people's last wishes had been taken into account when developing the care plans.

Requires Improvement

Is the service responsive?

Our findings

People were not able to tell us if they had been involved in making a decision about moving into the service so we spoke with family members. Relatives told us they were consulted when possible about their loved one's care. One visitor said, "(My relative) needed to move into a care home quickly and they came here on a temporary basis. I didn't want them to move into a care home, but once they were here I wanted them to stay". Another relative said, "I was a bit unsure because I didn't have a look round, but it could not have worked out better". Two more people's relatives commented, "I was involved from the start" and "The manager worked really well with us as a family when (my relative) moved in. We always knew what was happening. It made things so much easier"

One person's relative, told us they were, "Worried about (their relatives) weight". They had not been told by staff that a referral had been made to the dietician for support for their relative. If the relative had been told about the referral this could have stopped them worrying about their family member. We asked the registered manager about this and they told us that they were 'not aware' that the person's family had not been informed. The registered manager stated that they would address this and make sure the family knew about this referral and any outcomes. Most people's relatives, however, told us staff kept them informed about anything that affected their loved one's care, such as GP appointments, falls or visits to hospital. Other people's relatives felt involved and told about changes in the care of their family members. One relative said, "Staff involved me when they were writing my Mum's care plan and I can see it when I want to". Another relative said, "I have seen the care plan. It looks fine to me".

People's care plans included information about their personal care needs, mobility, mental health, communication, nutrition, medicines and health care needs. The amount of information and guidance for staff about how to support people varied. Some people's care plans were detailed and gave staff clear information about the person's needs and how to support them. Others lacked information and the lack of detailed guidance could lead to inconsistency in support. For example, one care plan had not been updated to include the advice given by a health care professional so staff were unaware of the information. Staff were able to tell us, however, how they provided care and support to people and demonstrated that they knew each person well but the lack of detailed guidance could lead to inconsistency in support.

A full assessment was carried out for each person before they moved in, which took into account people's personal, physical and health care needs. The assessment was used to check whether staff would be able to meet people's needs. Although there were detailed assessments in most of the care plans we looked at, some assessments lacked information and people could not be confident that their needs had been fully assessed. One person's relative told us their family member had moved into the service at short notice, but staff had got to know the person 'quickly' and were providing the care their relative needed. Staff told us that when people moved in they got to know people and were told what people's needs were.

One activities coordinator worked at the service and knew people well. Activities were only being provided by the coordinator on two afternoons and one morning of each week. This limited the range of activities and pastimes that people could take part in on a regular basis. The registered manager was trying to recruit an additional member of staff to provide more activities for people to take part in. When the coordinator was available she encouraged and supported people to take part in nostalgia and memory quizzes, arts and crafts and different games that they enjoyed. On one of the days of the inspection some people were involved in a nostalgia quiz, although there were other people in the room who were not involved and were sitting with nothing to do.

Care staff supported people, where possible, to do things they liked. One person liked to help with the tea trolley and was supported to do this. Some people were interested in cars and helped staff to wash their cars. This was an activity they really enjoyed. There was a vegetable garden and staff encouraged people to become involved in gardening when they wanted to.

Entertainers and therapists visited the service regularly. There was a regular visit by a singer to keep people entertained. Some therapeutic sessions were held including musical exercises, reflexology and a visit by a 'balloon man'. A hairdresser visited regularly and one room had been altered to resemble a hair salon so people felt they were actually visiting a hairdresser.

Requires Improvement

Is the service responsive?

People were involved in different activities. One person said how they liked to wash the cars. Other people were laughing and joining in activities. Relatives told us they thought there were, 'plenty of things to do'.

Staff visited people who stayed in their rooms to prevent them from being isolated. Staff regularly visited people in their rooms and stopped to have a chat with them. Sensory decorations were placed in some people's rooms and staff said this was because they stayed in bed for reasons of ill-health. Staff explained that they changed the theme of the decorations on a regular basis so people had something different to look at. Staff told us they thought this gave people some comfort and told us people seemed to enjoy watching the different decorations.

There was a policy in place which gave people guidance about how to make a complaint. This was available so people and their relatives could access if they needed to. There was clear information about who people could complain to and timescales for investigations to be carried out. The complaints log showed that three complaints had been made and these were all acted on and responded to. People were given written responses with apologies, where necessary, so people and their relatives knew any concerns they had raised had been taken seriously and acted on.

People told us they would talk to staff if they had concerns. People's relatives told us they had no cause for complaint. They described the registered manager as 'very approachable' and, 'took time to listen to them'. Everyone we spoke with said that they would have no hesitation in speaking with the manager if they needed to raise any concerns.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives knew who the registered manager was. Visitors told us the registered manager was, "Very approachable" and that she was, "Always around". People's relatives told us the registered manager made time to talk to people, and one person's relative said, "We can speak to her whenever we want". All the relatives we spoke with told us the registered manager was supportive. One relative said the, "Leadership is great and the manager is really on the ball".

Quality assurance systems were in place to improve standards and ensure the service was delivered consistently and safely. A number of regular audits were carried out in order to test the safety and quality of the service. Some of the checks had not identified areas of risk which were found during the inspection. For example, the last quarterly infection control audit completed did not include checks on commodes or highlight the issues found during the inspection; which left people exposed to the potential risk of an unclean environment. Cleaning schedules used did not include any deep-cleaning tasks or checks of toilet brushes. Care staff were responsible for cleaning commodes, but did not have a schedule in place to make sure this happened.

Accidents and falls were audited, but the information was not always used to look at ways of preventing or reducing the likelihood of reoccurrence. Incidents were not always recorded, because staff did not always document when people were upset with each other. Monitoring these types of incidents helps to identify any patterns or trends which could then help to prevent them again in the future.

Not all records were accurate and up to date to ensure that people received the care and support they needed. Some records, such as care plans and associated risk assessments were not always up to date to include changes in people's care needs. Staff kept records and charts, of the care they provided to people. These included food and fluid charts and turn charts for people who needed to be moved when they were in bed. These were not checked to make sure people had received the care they needed. The monitoring records in one person's room had been there for a month, but had not been checked to ensure any changes to their needs had been identified and acted on by staff. Changes in weight had not always been checked to ensure staff made referrals to a health care professional when weight loss was identified.

The provider did not have effective systems in place that assessed, monitored and mitigated the risks relating to the health, safety and welfare of people using the service. Accurate and complete records in respect of each person were not always maintained. This was a breach of Regulation 17 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits and checks were completed to identify and address areas of improvement. For example, the number of staff hours was audited each week to make sure there were enough staff to meet people's needs. Staff training needs had been checked and although there was some further training needed, this had been identified. An area manager carried out regular checks on the service on behalf of the provider. A report was given to the registered manager along with any areas of improvement that had been identified. The area manager confirmed that anything that was brought to the attention of the registered manager was addressed immediately.

People and their relatives were given opportunities to share their thoughts and opinions on the service that was provided. A quality assurance questionnaire was sent out twice a year. The last questionnaire had been sent out in April 2015 and concentrated on obtaining people's opinions about the food. This resulted in a change to the menus. Feedback from people and their relatives indicated that they would like more choices and additional alternatives had been added to the menus. Comments had been made about the lack of activities and a new post had been created for additional activities coordinator to join the team, although at the time of our inspection the registered manager was still looking for someone to fill this role.

People's relatives were aware that they could attend 'relatives and resident meetings' if they wanted to. The registered manager said that she had tried to arrange meetings for people and their relatives to attend. She told us that these had not been successful. To encourage more involvement from people's relatives a cheese and wine evening had been arranged and some people's relatives had attended. Feedback and comments were welcomed by the registered manager and provider.

Requires Improvement

Is the service well-led?

Arrangements were made to maintain close links with the local community. People had been involved with a local farmers market until recently. The registered manager was looking for alternative ways to keep people involved. Local school children visited at Christmas. A memorial garden had been created and relatives and local residents had been invited to the opening of this. The registered manager said no one attended any day centres, but people were supported to go out locally where possible.

There was a commitment from the provider, registered manager and staff to be 'forward thinking', and they looked at new ways of improving the service. A new computerised system for care planning was being investigated. The registered manager stated that this would help improve the care plans and improve record keeping. The registered manager told us that the system would be checked properly before it was purchased. They told us this was because, "Technology has a place but a care home is about the human and compassionate element of care and this is the most important thing".

The mission statement identified their visions and values for the service and was understood by staff. One member of staff said, "Making people happy makes me happy and I wouldn't change that for anything". Other staff told us, "You have to think that this could be one of your parents. I want to treat people as if they were my Mum or Dad". Staff told us they were happy and fulfilled and that, "People come first here" and "I love getting to know people and I enjoy talking to everyone".

There was an open and transparent culture at the service. Staff told us they had, "Every faith" in the manager and they felt able to be honest and open both with her and the wider staff team. Staff reported being happy and content in their roles. Staff were invited to regular team meetings and were able to contribute and have a say about how the service was run.

Staff knew their responsibilities and were accountable for the care they provided to people. There was a sense of good team work with staff sharing information and supporting each other to care for people. Some staff had been given lead roles and supported other staff to develop. For example, there were lead roles in promoting dignity and care.

The registered manager maintained her skills and knowledge through ongoing training. She had completed a dementia pathway degree with a local university. This had resulted in some changes in the service such as developing a coffee lounge and implementing a 'no uniform' policy. She said that this promoted a more homely atmosphere to make people feel comfortable and at ease.

The registered manager was a member of the 'My Home Life' local group. This is an organisation that brings managers of care services together so they can share best practice tips. The registered manager also attended meetings with the district nurses and the local clinical commissioning group to help maintain her knowledge and keep up to date with any changes which may affect people using the service.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC checks that appropriate action had been taken. The registered manager understood her roles and responsibilities in respect of delivering the service. They informed the Care Quality Commission (CQC) of any adverse events as required by regulation.

There were a range of policies and procedures in place that gave staff guidance about how to carry out their role safely. Staff knew where to access the information they needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not managed and monitored all of the risks to people's health and safety and failed to mitigate any such risks. This included risks associated with falls, mental health behaviours and management of weights. The provider had not consistently managed medicines in such a way as to keep people safe. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured that all the premises and equipment were kept clean. Regulation 15 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place assessed, monitored and mitigated the risks relating to the health, safety and welfare of people using the service. Accurate and complete records in respect of each person were not always maintained. Regulation 17 (1) (2) (b) (c)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have proper procedures in place to obtain consent from the relevant person for care and treatment. Regulation 11 (1) (3)