Care Quality Commission

Caring Homes Healthcare Group Limited

Claydon House

Inspection report

8 Wallands Crescent
Lewes
East Sussex
BN7 2QT
Tel: 01273 474844
Website: www.caringhomes.org.

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Ratings

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

Overall summary

We inspected Claydon House on 27 and 29 April 2015. The inspection was unannounced. Claydon House is registered to care for 49 people. There were 39 people living in the home when we inspected. This was because the first and second floors of the older part of the building were undergoing up-grading, so the rooms on these floors were vacant while the improvements were taking place. People cared for were all older people. They were living with a range of complex needs, including stroke and heart conditions. Many people needed support with their personal care, eating and drinking and mobility needs. People living at Claydon House were also living with dementia. The manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Claydon House is a large house, which had been extended. People in the older building had residential and nursing care needs. People on the newer Admiralty wing extension were living with dementia. Due to building works people were only living on the ground and lower ground floor of the older building; mainly people with nursing needs lived on the ground floor and people with

Summary of findings

residential care needs on the lower ground floor. There were a choice of sitting and dining rooms on each floor. A passenger lift was provided between floors. The Admiralty wing had accommodation over three floors, two of the floors directly connected with the older building. Each floor had its own sitting/dining room. There was a passenger lift between floors. All rooms were en-suite and most included showers. Additional baths and toilets were also provided. There was a garden, which was wheelchair accessible.

There was a registered manager in post. They had been in post for approximately 18 months. A registered manager is a person who has registered with the CQC to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider for the home was Caring Homes Healthcare Group Limited, a national provider of care. The home was supported by an area manager from the provider.

The manager had worked to make improvements across a range of areas since they came in post, however some areas relating to documentation had not yet been completed in full. This was because some parts of some people's care needs were not documented and others were not always documented when their needs changed, although staff told us in detail how they met these people's needs. Other people's needs were fully documented and reflected what staff told us. The manager reported they had identified a need to support staff further with improving documentation. They had plans in place and were progressing this.

People told us they felt safe in the home. Staff were knowledgeable about safeguarding policies and how to recognise different types of abuse. The service ensured risks to people were identified and action taken to reduce risk, for example risk of falls and skin damage. Staff acted in a safe way when the fire alarm was activated. They followed the provider's policies to ensure people were safeguarded in the event of a fire.

People were satisfied with staffing levels. There were enough staff on duty to support people at busy times of the day such as meal times, and to support people with 1:1 time. Staffing levels were regularly reviewed to ensure appropriate numbers of staff were available when people's dependency changed. The provider had safe systems for the recruitment of staff.

Medicines were given out in a safe way. Medicines were kept securely and there were full records of medicines administration.

People reported staff were trained and able to meet their needs. Staff supported people in an effective and safe way, for example when they needed to be supported in moving. New staff reported positively on induction to their roles. Staff were provided with the training they needed. Supervision systems ensured individual staff training needs were identified.

Staff were aware of their role in supporting people who lacked capacity and of the Deprivation of Liberty Safeguards. Where decisions needed to be made in a person's best interests, these took place and involved all relevant parties.

People's medical needs were promptly addressed, including involvement of a range of healthcare professionals, for example the community psychiatric nurses. People who were assessed as being at nutritional risk were identified and supported in the way they needed to maintain or increase their weight.

People were positive about the meals. There were systems to ensure people who were living with dementia could choose what they wanted to eat. Where people could not support themselves independently to eat their meals, they were fully supported by staff.

People said the staff were caring and supported them in the way they wanted. We saw staff supporting people who were frail and/or living with dementia in a way which encouraged them in making choices and being independent. Staff were consistently respectful to people and ensured their privacy and dignity.

Staff were responsive to people. They ensured they got to know people, before they developed their care plans. Staff were aware of people's individual needs, developing care plans which responded to these needs, for example in relation to changes in their mobility.

Summary of findings

A wide range of activities were provided to people. These included individual and large group activities. Activities were available seven days a week and there were regular trips out of the home

People felt they could raise issues with the manager and if they did, the manager would take action. Records of complaints made by people showed the manager and provider took action where issues were reported to them.

People and staff made favourable comments about the management of the home. The manager had a well organised system for audit of service provision. Where issues were identified, action plans were in place and being progressed. Staff said the culture of the home was supportive to them. A member of staff reported "I think it is amazing here I like the staff and the residents."

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected against potential risk and safeguarded from harm.

There were sufficient staff in post who had been recruited using safe and effective systems.

Medicines were given out in a safe way and full records maintained.

Good

Is the service effective?
The service was effective

Staff had the knowledge and skills to provide people with the care they needed.

People's capacity was assessed and consideration of the Deprivation of Liberties Safeguards were considered, where relevant.

People's health care needs were managed effectively. People commented favourably on the meals. People who were frail or living with dementia were given the support they needed to eat their meals.

Good

Is the service caring?
The service was caring

People were involved in making decisions about how their needs were to be met. Peoples' privacy and dignity were respected. Staff were kindly and considerate to people, supporting them in a helpful manner.

Good

Is the service responsive?
The service was responsive.

People's needs were met when delivering care, including people with complex care needs and people living with dementia. There was a programme of activities for people, which supported the range of people with different needs who lived in the home.

People felt they were listened to if they raised complaints and were confident appropriate action would be taken when they raised issues.

Good

Is the service well-led?
The service was largely well led.

Some people's documentation did not reflect the care being provided. The manager was in the process of ensuring all people's documentation reflected the care given to them by staff.

Requires improvement

Summary of findings

There were full systems for audit of service provision and action plans were put in place where deficits were identified. There were systems for feedback from people, their relatives and staff. People commented favourably on the culture of the home.

Claydon House

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.

We visited Claydon House on 27 and 29 April 2015,. This was an unannounced inspection. The inspection team consisted of two inspectors 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.

Before our inspection we reviewed the information we held about the home. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection, we spoke with 24 people who lived at the home, three visitors, 14 staff, including care workers, registered nurses, the chef and domestic workers. We also spoke with the manager, the deputy manager and area manager for the home.

We looked at areas of the building, including people's bedrooms, communal areas, bathrooms, the medicines rooms and laundry/sluice room. As some people had difficulties in verbal communication, 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 made observations of how people were, and support they received from staff throughout the inspection. We also observed lunchtime meals and medicines administration rounds.

We 'pathway tracked' five people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed the records of the home. These included staff training and supervision records, medicines records, risk assessments, audits and policies and procedures.

Good

Is the service safe?

Our findings

We received favourable responses when we asked people if they felt safe in the home. One person said they felt "very safe," another person told us "I couldn't have coped at home anymore, I fell down – I'm safe here".

We talked with staff about supporting people who may be at risk from abuse. Staff were knowledgeable about safeguarding policies and how to recognise different types of abuse. One of the domestic workers described a range of areas where they might consider a person was at risk. They told us if they had any concerns they would go to the member of staff in charge of the home. If they were not satisfied and felt they needed to take the matter further to ensure a person was safeguarded, they said they would do so, "it would not bother me at all." They explained the main matter to them was that people living in the home were safeguarded.

Staff were also aware people could on occasion be at risk from other people living in the home. A care worker described how their training enabled them to manage challenging behaviour by "talking calmly and trying to find out why they are aggressive." We saw the service's approach when supporting people living with dementia meant there was a low level of aggression between people. This was because staff identified and managed potential incidents effectively.

Many of the people had needs relating to vulnerable skin. Staff were aware of such risks to people and that they needed to document if a person sustained any injury. For example one of the people we met with had marking on one of their arms. Staff we spoke with knew about the marking, how they thought it had occurred and what they were doing to observe the person's condition and reduce their risk. When we looked at the person's records, a body map had been completed to show when the person had sustained the marking and actions taken since then. This reflected what staff told us. The manager had a system for auditing all such reports to reduce risk to people.

The manager of the dementia care unit described the need to ensure that while people were safeguarded from risk of injury, they did not reduce people's independence. They told us about a person who was no longer able to walk but who wished to continue to move around while sitting on the floor. They described the measures they had taken to ensure the person was safe when doing this. The service also used aids like pressure mats, to alert staff via the call bell system if people wished to move when they were on their own in their room, but could not recall they needed support to do this.

Staff we spoke with were aware of how to escalate concerns about accidents and incidents through management and the local authority. A care worker told us they could summon help quickly if they needed to support a person. This was because the home had a call button system which enabled them to alert staff from other floors if they needed help. All people had risk assessments completed, including assessments for risk of falls. If people did fall, staff told us about systems for assessing the person's condition immediately after the fall and for the next two days afterwards so they could monitor the person's condition and identify any additional factors for the person.

There were risk assessments in relation to the environment. These were regularly reviewed. They worked effectively in practice. For example, due to building works, the fire alarm sounded more than once during both inspection days. On each occasion, staff followed the fire safety procedure, meeting at the muster point, performing a roll call and assessing the potential risk. None of the staff assumed the fire alarm related to the building works and so did not follow the procedure. One of the members of staff told us this was important because it could not be assumed just because there were builders on site, the alarm had gone off accidentally. Staff showed an awareness of the security of the building. We were politely stopped by one of the domestic workers who did not know we were in the building. They asked to check our badge and authority for being in the home.

There were enough staff to meet people's needs. We asked people about staffing levels. A person who told us they had moved into the home recently said they "see more of them here," meaning staff, in comparison with where they used to live. We observed staff responded promptly when call bells were used. There were enough staff to support people at busy times like mealtimes. There was always at least one and generally more, care workers available to support people on each floor of the building. We observed numerous times when care staff were available to spend 1-1 time with people. Across the home, staff took their time

Good

Is the service safe?

to support people, the atmosphere was calm and not rushed. A care worker told us "we have enough staff to do this" about supporting people who needed additional support, including 1:1 time.

However, we received mixed comments from staff about staffing levels. One care worker told us "there is not really enough staff" on the dementia unit. This was not echoed by other staff. For example one care worker told us staffing was "normally fine." Some staff felt there were not enough registered nurses. One care worker told us "The nurses are always too busy to help us." The manager reported they had identified some registered nurses did not always feel working alongside care workers was part of their role. They were introducing systems to enable registered nurses to be more directly involved with providing direct support and supervision to care workers when they were providing care to people.

As we had not observed any issues about staffing numbers, we asked the manager about some member of staffs' perception of staffing levels. They were aware of such comments. They regularly performed dependency measures to enable them to assess appropriate staffing numbers and mix of skills to ensure they could support people. One of the heads of care told us this meant "staffing is fine" and they could adjust staffing levels if the dependency of people changed. Also where a person needed additional support, for example if their behaviours put them at risk due to a change in a medical condition or an infection, the manager could ensure 1:1 support for the person where they needed it.

The provider had clear systems to ensure only staff suitable to work with the people cared for in the home were recruited. The manager told us they were awaiting some staff to come into post. This was because they were waiting for relevant documentation, including confirmation from the Disclosure and Barring Service that prospective employees were safe to work with people. They said while it would be good to have these staff in post, they knew it was not safe for them to be employed as a member of staff until they had received assurance that they were safe and suitable to work with people. The provider also centrally collated information to ensure all staff who were employed from abroad had full proof that they continued to be authorised to do so by immigration authorities, regularly checked. All registered nurses were regularly checked to ensure they had maintained their registration with the Nursing and Midwifery Council.

People said they received their medicines when they needed them. People were given their medicines in a safe way. Registered nurses carefully checked medicines administration records before they administered medication to people. They locked the medicines trolley when they were not with it. They only signed the medicines administration record after they had given the person their medication. The service had clear systems for checking on stocks of medicines and to ensure they were stored in a safe way. Where people were prescribed medicines on an 'as required' basis, there were clear protocols relating to the reasons why they were to have the medicines and how often they were to be administered. For example, one person was prescribed a mood-altering drug on an 'as required' basis. There were clear records which would enable anyone not familiar with the person to assess why they needed this medicine and when it was to be administered. Where people needed prescribed skin creams applying, each person had a body map which documented where they were to have the skin cream applied and how often.

Good

Is the service effective?

Our findings

People told us staff were trained to meet their needs. One person said "The girls, they know what to do." Another person told us "Carers are very well trained and polite. You couldn't ask for more." A person said when they visited, they always saw the same standard of care, so there was "Nothing to be concerned about – lovely staff."

Staff met peoples' needs in an effective way. For example, staff supported people who needed help to move in a safe way, using equipment correctly for people when needed. They also always made sure people knew and understood how they were going to support them in moving. Staff reported they had been trained in other areas relating to supporting people with a disability. For example, we saw a member of staff supporting a person to eat. The person was not able to open their mouth much. The carer worker supported them using a small teaspoon, putting small amounts of food on the spoon. They checked throughout the time they were supporting them that the person was able to swallow safely, as well as checking they enjoyed their meal.

We met with a new member of staff. They told us their line manager "Did a fantastic job inducting me," "I've been made so feel welcome." The induction programme included basic training such as moving and handling and hand hygiene. It also included managing challenging behaviour, to ensure new staff understood how to effectively support people who were living with dementia. New staff were shadowed for the first two weeks until they were confident and competent in their new role.

Staff told us they were supported by a range of training, both e-learning and taught sessions. The deputy manager was in the process of organising internet access for two computers so staff could research any specific areas relating to meeting people's needs, while they were on duty. A member of staff who had recently been promoted told us they felt supported by the management team. Training records were audited by the manager so they could ensure all staff were up to date with necessary training.

Staff told us they received supervision from their manager monthly. Records supported this. Job role and any issues the staff member wanted to raise were documented, as well as any training needs. Supervision was recorded in staff personal files with a checklist documenting areas of concern and standards examined. For example one newly employed registered nurse told us they felt they needed up-dating in medicines administration. This had been identified by the manager and there was a planned date for this training.

Many of the people living in the home were assessed as not having capacity, due to living with dementia and due to their changing complex medical conditions. All of the staff we spoke with were knowledgeable about the Mental Capacity Act. 'Best interest' meetings took place when needed. For example, a 'best interests' meeting had recently taken place for a person in relation to decisions about hospital admissions, should they become more unwell. The 'best interest' decision for this person specified medical conditions where the person could continue to be supported by staff in the home, rather than be admitted to hospital. This was so they could remain with staff they were familiar with and not be placed under additional stress by being moved to an environment which was strange to them.

Staff were aware people's capacity could vary, sometimes throughout the day. They told us about the importance of assessing peoples' capacity at the time they gave care. For example staff ensured they checked with all people who were attending the afternoon entertainment if this was still what they wanted to do, even if they had expressed an interest earlier in the day.

Staff were aware of their responsibly under the Deprivation of Liberties Safeguards (DoLS). No-one was subject to a DoLS when we inspected. The manager had made applications to the Local Authority in the past, when relevant. Staff we spoke with were also aware of their individual responsibilities under DoLS. For example one person had bed rails in place. Several members of staff told us the person had a tendency to roll out of bed if they were not there. Putting the person's bed close to the floor with crash mats had been considered as an alternative safety measure, but the person would have been deprived of being able to sit up independently and being able to see out of their bedroom door and window if they did this.

The service cared for some people who were very frail and who had variable medical conditions. Staff contacted people's GPs promptly when people's conditions changed. A person had experienced frequent urine infections. Staff had worked with the person's GP to ensure these infections

Good

Is the service effective?

were treated in the most effective way for them. Staff also sought assistance from other relevant health care professionals. One person who was living with dementia had changing dementia care needs, the community psychiatric nurse had been consulted regularly to ensure the person was safe and not distressed. The staff reported on how they were supporting the person, following this advice.

People commented favourably on the meals. One person told us "The food is excellent you get a choice of three things." We saw a person who was being assisted to eat smiling at the care worker who was supporting them, saying "now I do like this." A person said "ooh this is lovely" as they tasted some apple juice brought to them. People said they could choose what they ate. One person told us they had asked for a banana at breakfast and they always got one.

We observed a lunchtime meal. People sat at tables with cloth tablecloths. Salt and pepper were provided for people to use. Drinks were given in cups, not beakers. The chef assisted people who were living with dementia by plating up the meal choices and letting people look at the meal to decide which they would prefer to eat. One person wanted some of both meals. The chef gave them what they had chosen. Staff sat with people who were eating, supporting them in both eating the meal and making the mealtime a social occasion. People who needed support to eat were given their meals in a careful way by staff. Staff did not hurry people in any way, giving them the time they needed to eat their meal, at their own pace.

Many of the people living in the home were assessed as being at risk of weight loss. The manager had recently introduced a 'traffic lights' system to indicate which people were at particular risk of weight loss. The chef was aware of how to effectively support people, including the use of fortified diets. Where people were at risk of weight loss, they had clear care plans. For example one person's care plan stated they did not like "Lumpy foods." They were supported to eat their meal by a care worker who carefully checked each spoonful to make sure there were no lumps in the mashed diet they were given. Many people who are living with dementia find it easier to eat 'little and often.' There were a range of 'grazing' foods available. These included chopped up fruit as well as biscuits and sweats. People helped themselves to these as and when they wanted.

All people who had food and fluid charts had them completed regularly. Fluid charts were totalled every 24 hours to review if a person was at risk of dehydration. The manager of the dementia care unit told us because the people living on their unit could vary in how much they were able to drink in 24 hours, they were planning to establish an average intake for each person. They would then have an individual base-line for each person to discuss with healthcare professionals as relevant. Changes in these averages would also give staff an early indicator in an alteration in the person's condition.

Good

Is the service caring?

Our findings

People described the home as a caring service, which supported them in the way they wanted. One person told us warmly "They're very caring," another laughed and said "They spoil you." A person told us "You couldn't have more, you couldn't fault them. There was a hair in my eye and the carer was very attentive and helped me." A person described a particular member of staff as "Very human."

Staff respected people's choices and supported relationships. The home cared for two people who were siblings. One of these people said they were so pleased the way staff ensured they sat together all of the day, when they wanted to. They said this made "A lot" of difference to them both and made them feel "Comfortable."

Staff supported people in a respectful way and ensured they could make decisions. One of the people on the dementia unit finished their drink and put it down on the table by them. A few minutes later they said to the care worker that they had not had a drink all that morning. The care worker was very polite and supportive to the person and went and got them the drink they asked for. At lunchtime a person changed their mind several times about what they wanted to eat, both before and during their meal. Staff respected their wishes and made sure the person was given what they felt they wanted to eat at the time. People who remained in bed all the time had different programmes on their radios or televisions, depending on what they wanted. One person had Christian radio on. The member of staff who was supporting them told us how important this was to the person. This preference was clearly documented in the person's care plan so staff unfamiliar with the person would know this was what they wanted.

Staff supported people as individuals and ensured their choices were respected. A person was asleep before lunch. A care worker gently woke them up, making sure they were fully awake before they reminded them it was lunch-time. The care worker did not wake another person who was in the same room. We asked them why this was, they told us the former person became distressed if they missed a meal, the other person did not like being woken up until they were ready. Once this person had woken, they would let the chef know, and their meal would be prepared.

When staff supported people they made sure their dignity was maintained and they were safe. A person was restless in bed and threw off their covers. The care worker who was with them politely asked the person's permission to replace the covers, explaining why they were doing this and asking how they could make them more comfortable. When care workers left a person who remained in their chair in their room, they made sure they had their call bell to hand and also that they knew how to use it if they needed to, so they could summon assistance. A care worker noticed a person had placed themselves so they were not close enough to the dining table. They asked their permission to push them further in so they would not drop food on their lap.

Staff supported people who were anxious in a kindly and caring way. One person used their call bell regularly. Staff reacted quickly each time they did this. For example, one care worker knocked on the person's door, and asked, as if it was the first time today "How can I help you?" Staff were consistently polite to the person, including when they person could not recall why they had used their bell. The manager was helping a relatively newly admitted person into the lounge and offering them encouragement. The person was a bit tearful. The manager and care worker were kind and considerate with the person, took their time and settled the person in a chair. Within a few moments they looked relaxed and were talking easily with other people in the lounge. One person wanted to go to the toilet and asked a care worker to come with them. The care worker said "Of course I'll come with you" and they walked out of the sitting room together, relaxed and laughing with their arms linked.

Care workers respected and involved people. One care worker was assisting a person who remained in bed but, they were interrupted by someone who said they were worried about something. The care worker asked the person they were helping "Is it OK if I go and help her? I won't be a moment." They returned promptly after they had assisted the other person.

Staff told us "The focus is on the resident." They said they understood about maintaining people's privacy and dignity. They gave us examples including; "Make sure they are covered." "Knock and wait for a response before entering a room." "Give personal care when they are ready."

Good

Is the service caring?

Staff also described the importance of choice in people's daily lives such as; "Letting them wake on their own." "Giving them choice about when they get up and go to bed." "Offering them lunch in their rooms or in the lounge."

Good

Is the service responsive?

Our findings

People said the home responded to their needs. Recently one person's condition had changed. The manager had booked a prompt and full review of their care plan, including involvement of their family to support the person, so an up-to-date care plan could be agreed. People signed their own care plans and where they were living with dementia or were frail, their care plans were signed by their relatives.

We met with a person who had been newly admitted. They were not able to say much about the home as they said they were settling in. The manager of the dementia care unit reported it was important to allow a person to settle into the home before they developed their care plan, because they needed to get to know people as individuals first. They had taken base-line information such as the person's weight and would record their fluid intake for a month to find out what they liked to drink and their pattern of how they liked to have their drinks during the day. During the person's first month in the home, they would establish with them how and when they preferred to be supported, for example with their personal care. Once they had established this and other matters, they would start supporting the person by drawing up their full care plan.

Staff told us because some people had difficulties in communication, it was important to make sure relevant matters were documented. For example, we saw one person varied in their mobility, sometimes needing more help than at other times. Staff responded to the person in the way they needed at the time they wanted to move. The person had a care plan, which was regularly reviewed which showed how the home were supporting them to gain more independence with their mobility. The care plan also noted they experienced mood changes and staff were to regard this as significant as it indicated changes in their underlying medical condition. Care workers told us that they reported to the registered nurses "if anything happens."

One person said they had arthritis which could cause them pain. We asked staff about pain management. Staff told us it could be complicated to assess if people were in pain, particularly if they were living with dementia or had communication difficulties. They reported they needed to be aware of changes in people, for example changes in appetite or behaviour, as this could be an indicator someone was experiencing pain. The manager had recently introduced a simple chart which staff could use with people to indicate their levels of pain. They reported this helped assessments of pain so an appropriate care plan could be developed to ensure people's pain was reduced.

Activities were provided for people seven days a week, with a variety of activities arranged to meet individual needs and preferences. All people were given a copy of the weekly activities programme, so they could choose what they participated in. During the morning a cooking session took place in one of the sitting/dining rooms. It was well attended and clearly enjoyed by people. We observed the activities coordinator discussing the election and the local candidates with people at lunchtime, promoting interest and conversation between people. Several people had polling cards in their rooms placed ready for them should they chose to go and vote. There were also visiting entertainers. We observed a singer and musician entertaining a large number of people in the lounge in the afternoon. The activities coordinator provided activities for people in their rooms as well as in the communal areas. Activities included hand massage, music therapy, reading and art therapy.

Care workers also supported people with diversional activities when they provided care. A care worker told us about a person they were looking after who remained in bed all the time. They said the person could not communicate verbally but as they knew them well, they could tell what activities they enjoyed and what they did not. They also knew about the person's life history and used this information when talking with the person.

Plans were being made for the further development of activities. For example the garden was being adapted so that people with an interest in planting could do this outside. Flower beds were wheelchair height and people were able to assist with painting fences and flower bed surrounds. Sensory work was taking place using herbs. There were plans for barbeques outside in the summer and a garden party in the warm weather. A paddling pool was planned so that people could put their feet in the water on hot days. A person told us how much they liked the gardens to sit in summer and they appreciated the way visitors came and talked to them.

Good

Is the service responsive?

The home organised weekly minibus outings, including outings to ice cream parlours and a local garden centre and visitor attraction. A person described a trip to seaside, saying they had picked up shells. They showed clear enjoyment in their description of the trip out.

People said they could raise issues of concern to them. A person told us "The staff are very friendly, but if there was a problem then I would mention it to the manager straightaway – she's good." We asked a person what they would do if they were not happy about something. They said they would speak to the manager. They reported emphatically "oh yes, the manager would sort it out." A relative raised an issue with the deputy manager during our inspection. The deputy manager apologised to the relative and said they would look into the matter. The manager had already started the complaints investigation process while we were in the home.

The complaints procedure was available to people both in their rooms and the main entrance areas. The manager maintained a record of complaints raised with them. These showed they had been investigated and relevant actions taken. For example, there was a sign that the manager had put up, dated March 2015, apologising to people about reports that the quality of food needed improvement, and that she was putting in certain actions to improve the situation. This was followed by a residents meeting notice where the chef would attend the meeting to discuss what people felt about the changes in May 2015.

Several people and their relatives had raised issues about an increase in fees. These had been referred on to the provider, as they were responsible for setting fees. Due to these concerns one of the directors for the provider had attended a recent residents and relatives meeting to explain the need for a fee increase and to answer questions of concern from people about the increase. The meeting had been well attended. People reported they were pleased a director from the company had responded by attending a meeting to hear directly from them their concerns and complaints about the fee increase, and they felt clearer as to the reasons following meeting directly with them.

The manager reported they were next looking at a system to make sure she was informed of any verbal concerns raised by people with staff, so she could ensure all such issues were being dealt with in a consistent way by all staff.

Requires improvement

Is the service well-led?

Our findings

We asked people if they thought the home was well-led. People were favourable in their comments. One person said "It's very friendly, and very well run," another person replied by saying "It's a lovely, lovely home." A person described the manager of the unit they were living on as "Very good."

The manager had taken up post about 18 months before this inspection. The deputy manager had been appointed in December 2014. The manager told us the home had needed many improvements when they came in post. They told us about the developments they had made, particularly ensuring staff received the training and support they needed to care for people.

While the manager demonstrated they had made many improvements in the home and were working on developments, some areas still needed action. Care plans were set out with sections for 12 activities of daily living, some of which were very long. A member of staff described them as "unwieldy" and said it was difficult to access information about a resident quickly. Also, some people's care plans did not reflect all of their current needs. For example, one person's care plan from 2013 had been reviewed every month but had not changed since then. It stated, due to their high risk of pressure ulcers, they were to be turned every two hours. Their turn chart showed they were being turned every four hours. We asked staff about this, they said they were turning the person every four hours. The person's care plan had not been up-dated to reflect this change and the reasons for this change. Another person had two free-standing radiators in their room. Both were turned on and both had sharp edges where the person might injure themselves if they fell. We asked staff about this. They said the person became very distressed if they did not have these radiators turned on, as they perceived they were cold all the time, even if their room temperature was very warm. The reported the person was not currently at risk of falling and they judged the risk of distress to the person by not having the radiators in their room was high. These decisions about risk to the person had not been documented. This meant staff could not formally review these decisions if the person's risk changed.

Although some people's records were not an accurate reflection of their current care needs, this was not the case generally and many we reviewed fully reflected what staff told us. For example, staff told us about a person who could not express their needs verbally, who showed distinctive behaviours if they needed to go to the toilet. This was fully documented in their records. This record was clear and precise and written in a non-judgemental way. Staff told us about a person who was reluctant to drink, so they supported them with jellies to increase their fluid intake, as they liked jelly. This was fully documented in their care plan and their fluid chart recorded when they had eaten jelly, and the amount they had taken in, to support their fluid intake. A person had sustained a wound to their foot. Their records showed the progress of the wound to treatment had been regularly evaluated. The records reflected what staff told us about the person's wound.

We discussed these discrepancies with the manager. They were open to what we reported. They told us they were aware some staff still needed support with making accurate records, although the situation had improved since they came in post. They reported on examples of improvements such as staff now always documenting when a person had been given fluids and the amount they had drink. Also that registered nurses always completed medicines administration records at the time of administration. We observed this was the case for both these examples. The manager said they had identified issues relating to the volume of documentary systems used by the provider. They were working with the provider to review how care plans could be made more individual. They were also planning to support care workers in drawing up people's care plans with the people they were caring for, as it was the care workers who provided day to day care.

The manager had full systems for audit. These were kept in an orderly and accessible way. There had been a full infection control audit in April 2015. Following this a range of actions for attention had been identified. For example the audit had identified several of the bed mattresses needed replacing. There was an action plan, which was being followed, to address this. Audits included audits of where people had fallen. Where a person was identified as experiencing frequent falls, this was identified and review of the person's care plan took place, together with referrals to relevant healthcare professionals. The manager also reviewed these audits to identify if accidents were more common at certain times of the day or in certain areas of the home. The service was mid-way through building works to up-grade the facilities when we visited. The action plan

Requires improvement

Is the service well-led?

about improvements was displayed in the entrance area so any visitors to the home could look at it. An audit of the furniture and fittings across the home had taken place. Chairs and a bath hoist which we observed needed attention were already on order for replacement. The manager had audited reasons for staff turnover, including reviewing staff exit interviews. They had identified the reasons staff had left related to personal reasons, not dissatisfaction with their role.

The provider regularly sought feedback from people and their supporters using questionnaires. Feedback in the last questionnaires sent out had related to issues prior to the current manager's appointment. The manager reported due to the changes they had put in progress, they were in the process of sending out questionnaires to people, so they could receive feed-back on their opinions of the changes they had put in. Regular resident meetings took place, minutes of the meetings were posted on notice board for people to review if they wished. The manager had also recently sent out questionnaires to staff. They were being returned during the inspection.

We asked staff about the culture in the home. A member of staff told us the culture was of a very supportive management team. They said the manager's door was always open and they could raise matters with her whenever they needed to. This included a domestic worker who reported the manager was "Most supportive, door is always open." A care worker told us they had taken a problem to the manager and it was sorted out immediately. A member of staff said "The deputy manager is good and gives us a lot of support." Staff also told us that the regional manager was very approachable. A member of staff told us because of the culture in the home "It's a lovely place to work."

Staff spoke favourably about the changes brought in by the manager, which they felt had improved the home. Two care workers particularly reported on the 15 minute shift handovers. They said it made them more efficient. One said "We now really feel part of a team". A newer member of staff told us "I think it is amazing here I like the staff and the residents."

The manager was open to new ideas and keen to look at different ways of improving the service. For example, they had identified their documentary and risk assessment process for people who were at risk of pressure ulceration could be improved, so they could fully evidence they were following guidelines from the National Institute for Health and Clinical Excellence (NICE) on prevention of pressure ulcers. They were planning to progress this area by introducing a 'traffic lights' system for people at risk of pressure ulceration, as they had done for people at nutritional risk, so staff could have a high level of alert about the risk, further reduce risk of pressure ulceration to people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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