Calsa Care Limited

Vicarage Court Care Home

Inspection report

Vicarage Gardens
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Date of inspection visit:
23 January 2017
25 January 2017

Date of publication:
28 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Vicarage Court Care Home took place on 23 and 25 January 2017 and was unannounced on both days. The home had previously been inspected in June 2015 and found to be requiring improvement in all areas. There were breaches of the Health and Social Care Act 2008 regulations in relation to person-centred care, dignity and respect, good governance and notifications. During this inspection we looked to see if improvements had been made.

Vicarage Court provides nursing and personal care for up to 70 people with a specialist facility for people with dementia. On the days we inspected there were 54 people living in the home with 22 of whom were people living in the facility for people with dementia, and a further 14 received nursing care.

The registered manager had retired a week before the inspection A new manager had been appointed and was in process of registering with the CQC, and there had been a transition period between the registered manager retiring to ensure an effective handover with the new home manager. They were in the process of registering and were available on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives all told us they felt safe. Staff demonstrated what signs of abuse to look for and how to respond if any such concerns were noted.

Staffing levels were reflective of people's needs which meant people were responded to quickly. We observed high levels of communication between staff when they were responding to call bells which helped efficiency of support further. All necessary checks had been carried out prior to employment of new staff. Although there were some issues with the recording, we found medication was administered, stored and recorded correctly.

We had concerns around moving and handling practice and documentation as not all staff appeared confident with assisting people to move and there was a lack of clarity as to how some people were to be supported if they had variable mobility. We spoke with the manager and registered provider about this who agreed to action immediately. We confirmed improvements were actioned with further training being provided and amended documentation implemented.

Staff had access to regular supervision and training. They were encouraged to develop in their roles and the home promoted learning. This was evidenced through individual and group supervisions alongside regular staff meetings for all staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Most support with nutrition and hydration was improved form the previous inspection as people had choices of drinks and meals, and any preferences were known and met. However, the deployment of staff occasionally meant a lack of supervision for people needing this at mealtimes and some care records did not indicate the required food consistency for people even though kitchen staff did provide this correctly.

Positional changes were offered to most people on a regular basis and were recorded accurately.

Care staff demonstrated a high level of commitment to supporting people, being responsive to their needs and emotions and acknowledging distress with kindness and patience. People were involved in reviews of their care wherever possible and their wishes regarding end of life care had been noted where discussed.

There was a range of activities throughout each day, both for groups and individuals and the home had plenty of resources to engage people. We saw much higher levels of interaction than previously and this added to the positive atmosphere in the home.

Care records reflected people's needs and aided staff to build a good picture of someone through their health and social care needs.

Complaints were handled by the manager promptly and with a thorough investigation ensuring lessons were learnt if necessary.

The quality assurance process had developed since the previous inspection and we saw evidence of effective communication and instructive meetings to assist staff in care delivery. However, the quality assurance system had failed to identify areas where practice was not meeting best practice such as around moving and handling, medication and mental capacity assessments.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were concerns around moving and handling techniques and documentation as some staff lacked in confidence and guidance as to appropriate practice.

People and relatives said they felt safe, and staff had a sound understanding of what action should be taken if they had concerns.

Staffing levels were appropriate on both days of the inspection and staff were responsive to call bells.

Medication was stored, administered and recorded correctly although there were minor issues with topical, 'as required' and covert medication.

Is the service effective?

Requires Improvement

The service was not always effective.

People were offered more choice than at the previous inspection.

Although people's consent was sought on a day to day basis the documentation around mental capacity was sometimes contradictory.

Staff had access to supervision and regular training which helped promote their own development.

We saw evidence of good engagement with external health and social care services.

Is the service caring?

Good

The service was caring.

Staff were empathetic and kind in their responses to people, being aware of distress and need appropriately.

Reviews had taken place with people and their family where appropriate, and the keyworker system ensured care records reflected current needs.

People's end of life wishes were recorded where they had been willing to discuss this.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities that were organised in small groups and appropriate to their needs.

Care records were person-centred and reflected people's needs and preferences.

Complaints were handled in a timely and thorough manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, relatives and staff all spoke very positively of the home saying there was a welcoming atmosphere.

Although the manager was new in post, they had developed key plans and ideas to take the home forward.

The quality assurance processes were much improved but the lack of scrutiny of moving and handling practice meant people were placed at risk.

Vicarage Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 25 January 2017 and was unannounced on both days. The inspection team consisted of four adult social care inspectors on the first day, and one on the second day.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also reviewed all information we held about the service including notifications and other intelligence from the local authority.

We spoke with eight people using the service and seven of their relatives. We spoke with nine staff including three care workers, one senior carer/team leader, one nurse, one member of the kitchen staff, the quality assurance lead, the manager and the registered provider.

We looked at twelve care records including risk assessments, three staff records, supervision records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe. One person we spoke with said "There's always plenty of staff day and night. There's someone there 24 hours." Another person told us "Yes, I feel safe. It's the general atmosphere and organisation." One relative we spoke with said "I feel [name] is safe. This is based on the five years they have been here and past experience of other homes. I know they are well looked after." The relative continued "I have recently been ill and not able to visit as often as I would normally but I have never any concerns regarding [name]'s care." Another relative told us "I feel [name] is very safe here. That was one of our main concerns, but yes, they are safe." A further relative who visited regularly said "I've never seen anything which concerned me."

Staff were able to identify possible signs of abuse or neglect such as bruising, disclosure or a change in a person's behaviour. One staff member said "We report this at once, and also any incidents between residents." Another staff member told us "We need to observe body language, be aware of bullying as well as physical or sexual behaviours." The manager was aware of current safeguarding concerns and had recently had involvement in one situation. This was reported appropriately to the local authority and to the Care Quality Commission. The manager was keen to stress each incident was seen as a learning point and if practice needed to change as result of an investigation this would happen, whether through further training or sharing of wider themes through staff meetings.

Risks were assessed in relation to individual need such as frequency of falls. Each person's level of risk was determined according to a series of questions and generic measures suggested to reduce risks wherever possible such as ensuring call bells were in reach, beds were at the lowest height and referrals for specialist equipment if required. There was a falls log which recorded the events surrounding the fall and falls review which evaluated documentation to see if any further risk reduction measures could be implemented. One person had a tendency to push themselves forward in their chair, increasing their risk of falls and so a special chair had been obtained to support this person with the minimum of restraint. This decision had been discussed and recorded with all appropriate parties which meant the home had acted in accordance with the Mental Capacity Act 2005 to ensure the safety of this person.

One person's care record evaluation dated 5 December 2016 stated "[Name] is now to be hoisted. Staff are to fully support [name] while transferring." However, when we looked at the moving and handling risk assessment the information contradicted this statement. On 15 January 2017 it was noted 'Does require hoist at times'. The risk assessment considered physical, psychological and environmental hazards which included a person's skin condition, communication difficulties and stability along with their cognitive abilities and made reference to the person 'displaying challenging behaviour' but gave no indication as to the definition of this or examples of how this manifested itself. This was not helpful to staff who needed to understand how best to support this person to promote co-operation and provide reassurance.

In another record we observed the person had been nursed in bed since August 2016 but there was no reference to this in their moving and handling risk assessment although we did see evidence of regular positional changes in their records. This person had a thorough risk assessment for bed rails and yet was not

deemed to be at risk of falling out of bed so we could not determine the value of these. We observed a further person was always transferred using a wheelchair without footplates attached. When we asked staff about this they told us it was because the en-suite was not accessible with them on. This practice was unsafe for the person as they could have toppled out of the wheelchair if they had put their feet down.

We asked staff how they ensured safe moving and handling. One carer said "I usually follow the person if they are mobile and we always have two staff if someone needs to get into a wheelchair." They were aware people had personal slings, wheelchairs and where used, walking frames, and the importance of ensuring brakes were applied and people had their feet on the foot plates. However, as mentioned above, we did not always see this in practice.

Alongside the moving and handling risk assessment was a 'safe system of work' or moving and handling plan. This did not always contain enough specific detail such as the hoist or sling to be used and the method, e.g. log roll or where the loops were to be attached. Where people's mobility was variable it was not recorded how staff were to try and promote independent movement first or at which point they were to consider the use of equipment. This is crucial to minimise the risk of harm to people as staff need to be clear when it is safe to try and support someone to do it themselves or when equipment is needed.

Our observations revealed some staff lacked confidence when assisting people to move. One person was moved with the assistance of a rota stand but were very unsteady on their feet and staff seemed unsure of how to transfer this person. We observed two staff try and put a sling around a person to move them but they did not want to move. They tried to encourage them but the person refused. There was no assessment for moving and handling in this person's file, just referring to a "wheelchair to mobilise but can stand with the assistance of one or two carers depending on [name's] stability that day." However, despite an evaluation dated 12 December 2016 saying this was 'all current at present' we noted the person had a plaster cast on their arm and so was not reflective of their level of need. Later in the day we observed a much more positive attempt to get this person to stand by the use of distraction techniques to minimise the distress and anxiety with being hoisted.

We questioned staff why they were using the same sling for some people and were told "If people are always hoisted a sling is provided individually but if they have variable mobility then they use a shared sling." This should not happen as each person should have their own sling for infection control purposes and for safe moving and handling as each person's needs are different. These examples constitute a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always being supported to transfer in the safest possible way and by staff who were competent at handling people.

The manager said the home had a number of in house moving and handling trainers. We checked the training records of these staff and found they had renewed their training in October 2015. Following our concerns the manager agreed to request further training for all staff involved in moving and handling and we were informed this had been arranged for 9 and 14 February 2017 along with a revision of the paperwork to evidence specific moving and handling requirements which showed the registered provider was responsive to our concerns.

We observed one person being encouraged by staff to eat but even though their care plan specified they were to be supervised when eating due to a risk of choking we observed this was not happening during our inspection and they were left alone at times to eat. When we questioned staff they said the person no longer required this level of input and therefore the care record was misleading. We did not find any updated information from the SALT team to suggest anything had changed.

People's care records contained Waterlow scores which identified the level of risk of skin breakdown and included photographs of various stages of pressure sore to help alert staff to possible concerns. Where people had fragile skin, staff were responsive to any marks or skin tears, noted any concerns on a body map and contacted nursing staff as required. A newer staff member was able to tell us about the importance of pressure cushions.

We did observe one person who was supposed to be on a pressure cushion not sitting on one either day we were at the home despite their skin risk assessment saying they were at high risk of skin damage. This was highlighted to a senior member of staff on the first day including the information which stated the person should have four hourly position changes. In their positional change chart the last position change was at 08:15 and we spoke with the senior staff member at 13:25. This meant the person had not received pressure care according to their care plan. We observed other instances of people being supported to move at regular intervals and these actions were recorded in their positional charts.

We found people had current personal emergency evacuation plans in the event of a fire or other serious incident which identified what equipment would be needed in such an instance. We saw the home had conducted regular fire checks including a daily survey of all fire exits, weekly fire alarm tests and regular fire drills. Analysis of accidents and incidents was robust as accident forms were completed in full. Monthly checks in relation to falls were conducted to ascertain if there were any trends emerging based on type of fall, location, time and other factors such as mental or physical health deterioration. For each accident daily records were completed, people's falls plan reviewed and risks re-assessed if appropriate. We saw action had been taken in requesting appropriate support or alternative equipment where necessary.

We checked staff files and found all necessary checks had been conducted prior to employment. Interview notes showed in depth questions and role play scenarios to ensure staff recruited had the right aptitude for the post. References were requested and identity checks carried out including DBS (Disclosure and Barring Service) Checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. The registered provider stressed all new staff were on a three month trial and at the end of this people's views were obtained in the home to determine if they thought the new staff member was performing well. This was all considered alongside the evidence from two supervisions conducted during this time. This meant people in the home had some say in who provided care to them and their views were taken seriously.

One relative we spoke with said "Staffing levels do fluctuate. It depends on how busy they are. [name] comes down every day to the lounge." Another relative told us "All care is good. Staffing levels are fine and there's always someone around." Staffing levels were determined through the use of a comprehensive dependency tool which considered each person's needs around communication, mobility, skin integrity, nutrition and personal care support. One staff member also said "I think there are enough staff to meet people's needs and to do other things like chat with people." Other staff echoed this viewpoint.

The home was currently using more staff than the tool advised due to the level of need required which showed they were considering people's needs first. The manager explained the registered provider was constantly seeking new staff to ensure they had plenty to call upon if needed but stressed the staff team was stable. If agency staff had to be used we saw appropriate checks as to their experience and suitability were conducted first.

When the call bells rang, staff were alert and responded promptly, telling colleagues they were doing so which meant all staff were aware of what each other was doing. We observed staff being aware of potential risks. They intervened swiftly when one person stood up who was unstable supporting them and asking

them what they wished to do, taking their time to move the person safely and with clear direction.

In one person's record we saw one person regularly refusing their medication and on 14 November 2016 the GP was contacted who agreed to the medication being given covertly. We advised the registered provider this was not in accordance with the NICE guidelines as a pharmacist needs to be contacted to discuss the most appropriate method of covert administration. However, we did note a month later all medication had been stopped by the GP as the person continued to refuse to take any.

We observed a staff member putting medication in one person's yoghurt and they told us "It's OK, we've got a covert in place." However, when we looked at this we saw evidence of the capacity assessment which indicated they could not understand the risks associated with not taking their medication, but only a letter from the GP to say this was in the person's best interests. The relative had signed consent but there was no evidence to say they had the authority to do so and again, there was no evidence of pharmacist involvement to agree this was the most appropriate method.

Staff's competency in relation to medicine administration was assessed on a regular basis by the home's quality lead. One staff member we spoke with was able to explain the whole procedure for the administration and safe storage of medication in detail. They told us the importance of checking if people were in pain and when it was necessary to seek further medical advice. Other staff we spoke with had a similar level of understanding.

We checked the clinical room and found fridge and room temperatures were monitored daily. Controlled drugs were stored, administered and recorded correctly. People's allergies were recorded clearly in their care records and on their Medication Administration Record (MAR). Their preferred method of taking medication was also noted, for example 'on a spoon with thickened fluids'. Where people were receiving PRN (as required) medication protocols were in place to support staff as to when to offer these although some of the detail could have been more specific. We also noted some PRN medication was being given at regular intervals without evidence of a medication review. The manager agreed to arrange these reviews urgently.

Body maps were completed with evidence as to where skin had reddened or broken down, and creams applied where prescribed. However, we found people did not have topical medication charts in their rooms. Care staff applied creams and nurses 'presumed' care staff had applied and signed the MAR. This is not safe practice as it meant staff were signing for tasks they had not witnessed and there was no overall scrutiny. By the second day of the inspection a topical medication chart had been implemented in response to our concerns.

In the externally assessed infection control audit for 2016/17 the home had scored 94%. Staff had access to personal protective equipment and we saw appropriate infection control measures in practice.

Requires Improvement

Is the service effective?

Our findings

One person said "I don't mind it. The food is usually alright." Another person said "The food is good." One relative said "The food is spot on. The Christmas dinner was fantastic. The home provided it for all the families."

We saw the dining tables on the ground floor were presented well with tablecloths, flowers and a lunchtime menu card offering two choices of main course and dessert. There was also a small sign on the wall telling people they were able to request unlimited food and drink throughout the day. People were offered a choice of drinks throughout the day, and were asked how they liked them which was an improvement from the previous inspection. There was a display of sweets for sale on a 'fairground' trolley in the lounge area. We observed lunchtimes in all areas of the home and people appeared to enjoy their meals. Teatime was also a positive experience with people being offered a range of foods and second helpings.

In the Forget-Me-Not unit people were addressed by name and able to sit in the conservatory or main dining area as they wished. Blinds had been installed across the conservatory roof which helped shield people from the direct sun, which although cold outside, was still strong through the glass. People had their meals brought to them individually from a kitchen unit which had been created in the downstairs dining area, and had both juice and hot drinks available. One person took a dislike to their dinner and was immediately offered an alternative. We did not hear people being advised what was on their plates for the first course but they were for their dessert. Neither did we observe any condiments on the table although they were quickly produced when requested. At some points of the mealtime only one staff member was available to support people which meant not all people were observed fully, for instance when one person tried to put a fork into the juice jug as the other staff had congregated in the kitchen area to serve the meals.

We observed staff appropriately and sensitively checking a person with sight impairment was aware of the food on their plate. Meals were served on dark blue plates which can help people with dementia distinguish food options more clearly. One person was supported to eat their dinner at their pace and with good interaction between them and the carer who were discussing the music playing on the radio. Another person started to cough and carers were quick to respond offering some water. We did note people being asked just after their lunch what they would like for the next day at lunch and tea time. This was not helpful to people with dementia who might not recall their choice the following day.

Food preferences were noted in each file, a copy of which was with kitchen staff. We did note one person's care record referred to a soft diet but when we questioned the kitchen staff they were fully aware it food was to be pureed and we saw this provided.

People's weight was monitored monthly, or more often if needed and professional involvement requested if needed. Food and fluid charts were in place for people nutritionally at risk.

One person told us "I think staff are very competent." Staff had completed an induction which included key policy information around fire safety, personal care and health and safety. This was e-learning followed by

questionnaires to assess a staff member's understanding. One staff member told us "I have done training in moving and handling, fire, DoLS and MCA, person-centred care and dementia. I also shadowed three shifts before starting." We looked at one of the newer employees and found their moving and handling training was not yet completed in full, and they had not met the required pass mark for the mental capacity test. We spoke with the staff member who advised us they had completed the training but the form had not been completed in full. We also spoke with the registered provider about this and they assured us this would be completed and the test re-taken to ascertain competency. The staff member told us they had also shadowed other carers before undertaking any tasks themselves.

Supervisions were conducted although on a one to one basis including an annual appraisal. There were also group supervisions where specific topics were discussed with staff. In March 2016 the topic had been nutrition and hydration which included information about conditions such as diabetes, how to measure someone's nutritional risk through a Malnutrition Universal Screening Tool (MUST) and their body mass index. In a one-to-one supervision record we saw discussion around how the person learned best and how to support good practice with food and fluid charts, including keeping running totals of fluid intakes so staff knew whether a person was drinking enough. In addition to this staff had access to regular staff meetings to aid learning and development.

All appraisals were up to date and reflected personal objectives in line with the overall plans for the home such as effective management with all elements of the multi-disciplinary team and ensuring the action plans were completed as required. Staff were encouraged to share their skills and knowledge with other team members, and to undertake further training to develop their own learning. Comments included "Good team player and works well. Is caring and goes over and above to provide excellence to service users." The new manager explained they would be completing all the appraisals this year to ensure they knew their staff and their strengths and where they needed to develop.

We checked the training records and saw staff had attended courses in moving and handling, health and safety, food hygiene, fire safety, infection control, equality and diversity, safeguarding, dementia care and mental capacity. Staff had also received training in medicine administration where it was part of their role. One staff member said they had requested first aid training and the registered provider had arranged for this to take place on 24 January and 6 February 2017 for all staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

One staff member told us "We cannot deprive someone of their liberty without the lawful authorisation." They also knew if a person was unable to make a decision then discussions around what was in this person's best interests should take place. Their understanding of mental capacity reflected the legislation as they knew all people should be presumed to have capacity and that this could vary throughout the day. They said "Each time it might be a bit different so we offer people choices every time." Another staff member also

said "If a person was resistive to care we would offer reassurance and support. But if they needed more time we would leave them for a bit and return later." We observed staff seeking people's consent before undertaking any task with them such as moving and handling.

In one person's communication and cognition care plan we saw it noted the person was living with a diagnosis of dementia and they were to be 'offered full support when confused'. It continued "Due to their dementia [name] struggles to retain information or its understanding. Their fluctuating mental capacity makes it hard for [name] to make a decision. On some days [name] can make decisions like when they want to go to bed or if they want a drink." However, there was an associated mental capacity assessment in relation to 'day to day 'living which indicated the person did not have capacity to make day to day decisions.

The initial assessment was dated in August 2016 and the capacity assessment in October 2016. The latter was broken into specific questions around lifestyle where it identified the person could make decisions about eating and drinking, bed times and hair care but not about anything else. The person had a DoLS in place which included the condition to have regular reviews to ensure the DoLS was still pertinent and we saw evidence of these reviews. We saw evidence of other DoLS authorisations in place where required and monitoring of applications to the supervising authority to ensure people were not illegally deprived of their liberty.

Some people had capacity assessments in place for specific decisions such as the use of crash mat, use of the hoist and repositioning requirements. However, in another person's record we saw it recorded the person lacked capacity to 'make the right decisions' but did not specify what these 'right' decisions were. In one personal hygiene care plan it was noted the person was able to 'consent to care' but by the end of the same paragraph '[name] lacks capacity so all decisions are to be made in their best interests.' This did not provide clarity for staff about the person's ability to make decisions themselves.

Although we found some evidence of decision specific mental capacity assessments, few had been completed to include evidence of subsequent best interest decision making involving all relevant parties. One person's relative had signed consent forms for photographs and record sharing but we could not see any evidence they had the required authority to do so as the answers about whether they had a Lasting Power of Attorney were blank. In other records we noted a relative had Lasting Power of Attorney for finance alone but had signed consent forms for care which was not in accordance with the MCA and we saw a covert medication consent form signed by a staff member alone.

We did see a 'standard' statement in daily notes which read "[name] lacks capacity to make informed decisions so staff to make them in their best interests." However, we pointed out to the registered provider and home manager this was not necessary as if people lacked capacity this was supported in their files by specific mental capacity assessments and the recording of best interest decisions. We spoke with the manager about this contradictory information and they agreed to look at this area further.

We saw people had accessed external health and social care services as needed such as GPs, district nurses (if they were residential residents), dieticians, chiropodist and opticians. One person had seen the GP for medication reviews and following falls. The information was recorded in detail and referenced to information about key incidents where relevant. One relative said "They keep an eye on medication and are quick to call the GP if needed. They also contact me as well with any concerns." They had visited and noticed their relation had some reddened skin but were pleased to see action had already bene taken about this as staff had contacted the GP. In another record we saw someone had been sent to hospital on the advice but returned to the home with a course of antibiotics.

Rooms were decorated with people's personal effects and appeared homely. There were individual photographs and information on their bedroom doors, highlighting activities they enjoyed such as bingo or sewing. In the Forget-Me-Not unit tables were laid with juice and cups and there was appropriate signage to support people to orientate themselves. Walls were nicely decorated with relevant photographs and homely quotations. The home was visibly clean and there was a structured cleaning schedule being carried out although we did note some cushions looked stained.

Good

Is the service caring?

Our findings

One person told us "I am happy here." Another person said "The girls are very kind." One relative said "The girls are like family. One carer brought in some things for [name] just before Christmas. It was a lovely gesture." The relative was touched as the staff member knew exactly what their relation liked and had packaged it together nicely. The same relative also said "I have never seen any staff raise their voice although I have seen staff slapped by people in the home. No one retaliated." Another relative said "The staff are all friendly and they all know what they are doing." A further relative said "The staff are amazing. Even the registered provider knows everyone." They explained their relation had recently spent time in hospital and while there kept asking for a specific carer by name showing the positive relationship between staff and people.

Staff were attentive, warm and responsive in their approach with people. We heard one staff member say "I've got a barrowful of custard creams just for you, [name]!" which demonstrated warmth and humour and generated a discussion with the person about their preferred biscuit choice. We heard another staff member ask someone to 'put their foot up' as they would be more comfortable. They displayed courtesy and kindness. Staff chatted to people while they supported them with their drinks and we noted one staff member observe a person's drink had gone cold and so they made a fresh one for them. During the afternoon people were offered further refreshments and given time to make their choices.

We observed being positive, friendly and reassuring with people when performing moving and handling procedures. We heard one staff joke with someone they were the driver and the other person the navigator. This was well received by the person who laughed along with the staff. Later in the day when one person left the home as their respite stay had ended, we noted another person become anxious as their family had not yet visited. One staff member sat with this person and reassured them they would be visiting. The conversation referred to significant family and friends by name so it was clear staff knew this person well.

One staff member told us some one liked knitting and we saw this later recorded in their care record. One person requested support for someone sitting near them as they required the toilet and this support was provided promptly and discreetly. Another person had some bruising to their face and one staff member was able to tell us the person had had a fall a while ago. We found evidence of this in their care record. It was evident staff knew people well and had a current knowledge of significant care issues.

During lunchtime in the Forget-Me Not unit people were free to get up and move at will. One person wanted to walk to the other dining room and was encouraged to do so by another carer. We heard one staff member asked a person if they had finished with their tea cup "as I don't want to take it before you've finished, [name]" which showed consideration for that person. Another person had got up and was walking down the corridor and one carer went up to them and asked them if they were OK, and guided them towards the lounge area.

One person gave a carer a hug and the carer responded by saying "You make my day, giving me a cuddle and a snuggle" which was a lovely affirmative comment for the person who had lost the ability to

communicate easily verbally. We observed one person becoming quite distressed but staff were quick to intervene and reassure them. This generated a positive response for the person. Another individual was often saying they were lost but each time staff responded with comforting words and never showed any signs of impatience. We also noted one staff member speaking to a person very discreetly and sensitively for over ten minutes as the person had become very upset.

We observed the registered provider talk easily with people. They spent a lot of time in the home during the time we were there, passing the time of day with people, acknowledging them by name and asking after them. Staff also asked people how they were and we heard one staff member asking someone if they felt tired as they were aware they had had a restless night. The home received many visitors over the two days we were there and each one was greeted warmly.

A relative we spoke with told us "I have been involved in reviews. They are usually once a year. It's face to face meeting with a senior member of staff." Another relative said "Dignity is very good." A further relative told us "Staff encouraged their relation to be as independent as possible."

Staff told us there were handovers at the end of each shift and these were written down. We saw handover notes which detailed people's diagnosis, manual handling requirements and other key events around their mood and general wellbeing. However, these were left on view in the nurses' station which did not ensure people's information was kept private and we noted the cupboards containing people's care records were left unlocked which posed a risk that confidential information could be accessed.

The staff followed a keyworker system whereby the keyworker was responsible for updating their people's care records on a monthly basis. One staff member told us "This ensures files get read on a regular basis and helps to ensure someone knows the person really well."

People had end of life wishes recorded in their records where they had discussed these so all staff could see what people's wishes were including any cultural or funeral requirements. One staff member said "We support the family as well as the person. We explain their treatment and chat with family and doctors, and also the Macmillan team." Although staff knew of people's personal relationships it was not always recorded accurately in care records. One person had a life partner but was only referred to in the care record as a 'friend'. This meant new staff may not have appreciated the significance of this person when making decisions.

Good

Is the service responsive?

Our findings

One relative told us "The activity co-ordinator moves around the home. Anyone can join in the entertainment. There is usually something every day. Before Christmas it was lovely as a school choir came in." They told us gardening was offered as choice for people although their relation did not like this.

The activity co-ordinator was on leave during the days we inspected but one of the care staff had been assigned the task of providing some activities for people in the residential and nursing units. We spoke with one person and their relative and they told us how much they had enjoyed completing their memory book, especially when adding the photographs. During the afternoon of the first day we observed people discussing what pets they used to have and their parents' occupation. There was lots of laughter and reminiscing in a small group. We saw one person reading a newspaper and another playing a game on a tablet. There was a display of activities recently undertaken such as time spent in the garden and significant celebrations such as the Queen's 90th birthday. There was also a record of who had participated in which activities such as dancing, baking or gardening. In the Forget-Me-Not unit people were receiving manicures if they wished.

We looked in people's care records and found them to be person-centred in focus. Each record contained a front sheet outlining key information such as preferred name, date of birth. GP, any allergies and the person's key worker. There was also a photograph of the person to assist staff with identification. Other important information such as specific health conditions were also recorded

People had been assessed at the point of admission to the home and we saw these assessments had been updated and amended at various intervals since, usually when there was a particular change in need. Each aspect of a person's support need was considered such as mobility, communication, skin integrity, cognition, nutrition and hydration, personal care and medication amongst others. These needs were outlined with specific actions as to how to address these needs. In one scenario we saw a person was at risk of falls and so a crash mat had been placed at the side of their bed to limit the risk of harm.

Records reflected people's usual routines and preferences. In one record we saw "Usually has hair wash in their en-suite. [Name] is able to wash hands and face but needs help with the rest. They do not show much interest in choosing clothes, so decisions are made in their best interest." In another care plan we read how important it was for one person to be given their toothbrush so they could clean their teeth themselves.

Staff completed daily notes to show what support a person had received and significant information such as if a person needed medical attention and commented on people's emotional health as well. In one record we saw "[Name] seems to be in pain but refuses all pain relief despite encouragement to take it. This seems to be linked to their mood. [Name] is repositioned every three hours through the day to aid pressure relief." It was evident staff were supporting with pressure relief as this was cross referenced in the daily notes with the specific positional chart for that person. In another note we saw "[The activity co-ordinator] put music on for [name] to listen to whilst they did their nails and [name] found it relaxing."

In the Forget-Me-Not unit people were enabled to join an exercise class, during the afternoon of the first day, run by a local physiotherapist. They told us they had been involved with the home as part of the local NHS Vanguard Project, which sought to reduce hospital admissions, for the past three months and were about to hand over the responsibility to the unit manager to continue the class going forward. The physiotherapist told us in their opinion all staff had been very receptive to the class as they could see the benefit for all people who had participated.

The home had plenty of books, magazines, teddies, hats, jigsaws, a box of items including a large dice and some skittles. These were particularly used by people in the Forget-Me-Not unit. Music was playing in this unit and people were asked if the volume was appropriate and this was adjusted accordingly.

Communication between family and friends was noted in people's files showing if significant events had happened, such as a fall, this was reported to their relatives promptly. A relative also confirmed this was the case as "I am kept fully informed." Another relative said "The staff are really good. They tell me how [name] is or if they need any medical help. Like when they fell out of bed they rang me straightaway so I could go to the hospital with them. If I couldn't go they would have sent someone with them." A further relative said "They know my relation and their quirks. They keep me well informed and I can't fault them." All relatives told us they could visit whenever they liked and there were no restrictions.

We saw one person in the home wrote regular newsletters for all people to read. These were reflections on their time in the home and other memories. These were typed and displayed for all to share.

One relative said they would be happy to raise any issues but they had never had any reason to.
No complaints had been passed to the new manager from the previous one, but the new manager was dealing with one situation and explained what they were doing. This was appropriate and a timely response.

Requires Improvement

Is the service well-led?

Our findings

One person said "It's a nice place. I'm happy enough." Another person told us "I'm as happy as I can be out of my own home. I like my room very much." A further person said "I like it here." One relative told us "The registered provider is very passionate and involved in the home on a daily basis." Another relative said "I feel lucky [name] has a place here." A further relative told us "The boss always comes and says hello. It's a well organised home."

In one person's review with their placement authority we noted family members comments included "My relative's needs are well met. It's a pleasant environment, clean and well maintained. We feel able to address any issues with staff directly, that these are listened to and acted upon." One relative also told us "Staff are well organised. There's always someone in charge."

One person told us they had attended a 'resident and relatives' meeting and was happy to share their opinion. We saw in the minutes of these meetings people had been reminded there was an 'open door' policy where any concerns could be discussed and suggestions from people such as ensuring the use of subtitles on the TV were implemented. It was also noted people had said activities had improved and had found the split environments better to aid communication. People had requested water jugs on tables and we saw these were available. There was also evidence of discussion around the impact of living with a diagnosis of dementia on both the person and their family and friends. Meetings were held quarterly and forthcoming activities advertised such as visiting entertainers.

One staff member said "I would definitely want my own relative here. I think the care is good enough. I enjoy working here." Another staff member said "It's a really good home to work for." Staff told us they felt supported and encouraged to progress in their roles. One staff member was happy to tell us their team leader had noted they were only giving people tea but the importance of choices was discussed with them and they found this feedback very constructive. They all said they would be happy to approach the manager if they had any concerns. One staff member said "Teamwork is good here. We all get on quite well – it's like big family really." Another staff member told us "Staff roles are allocated at the beginning of each shift. It works really well. We all work well as a team." All staff were asked their opinion of new staff to ensure they were fitting in and developing in their role. They felt this was important to an effective staff team.

Staff said the registered provider was very responsive and aware of daily activities in the home, and if equipment became faulty this was repaired quickly. One relative said of the registered provider "If [name] sees me they will always ask how my relation is" and they also said their relation "calls this home" which they felt was a sound endorsement.

We saw evidence of regular staff meetings with both carers and nursing staff, and also head of unit meetings. One staff member told us they found these a useful information sharing opportunity and they were valuable. They said they had requested a meeting a while ago as staff morale was low due to high sickness rates and so a meeting was held. This had helped boost ownership by staff and attendance improved. Topics discussed included reflective practice and how staff can learn from seeing if things could have been done

differently, the importance and relevance of completing documentation in a timely and accurate manner, that staff should always be offering fortified puddings to those nutritionally at risk and all staff to complete their training as required. This showed the range of issues discussed focused on both staff competence and people's wellbeing, always with a view to making improvements.

The registered manager had retired a week prior to the inspection but the registered provider had enabled a six week transition period with the new manager before they left. They had been able to get to know the home and its residents along with the policies and procedures.

Specific audits were limited but due to the nature of staff meetings and communication all aspects of service provision were reviewed regularly. We saw a dining room experience audit which contained specific actions, all of which had been addressed promptly and monthly kitchen audits, again which were thorough. The care plan audits were robust and each scored a rating with action points within a specified timescale. However, there were issues with moving and handling practice which although responded to swiftly, should have been identified through the quality assurance processes.

All equipment had been checked under the Lifting Operations and Lifting Equipment Regulations every six months as required. There was also a maintenance schedule which considered frequent premises checks such as window restrictors, gas, electric and thorough room audits which considered painting, cleanliness, furniture security and bed, bed rails and mattress checks. These were completed on a minimum of a monthly basis and were individual as bed rails checks had each specific measurement recorded.

The registered provider told us they had recently had a full health and safety audit completed by an external auditor and were awaiting the report outcome. They also continued to use their external auditors who completed comprehensive quarterly checks. As a result of this, discussions had been happening around the storage of medication in people's own rooms in an attempt to further develop person- centred care.

We asked staff what they felt the values of the home were. One told us "It's a home from home. We promote independence with dignity." Another said "It's like a big family." The manager said "to ensure care is delivered, not just to people in the home and their families, but to the staff as well." They emphasised the importance of saying thank you to all staff which was endorsed by the registered provider. They strongly believed, in the short time they had been there, the home had committed and passionate staff and had observed some very positive interactions and awareness of people's needs.

The manager said they felt very supported by the registered provider and had benefitted greatly from the handover with the previous manager. This period of time had been used to observe and assess the home without the pressure of taking immediate responsibility and had helped shape their thinking about future direction. They had continued to complete daily walkarounds to meet people and keep an eye on activities in the home and had plans in place to implement meetings on alternate days to ensure information flowed in all areas of the home and key issues were identified and acted upon quickly.

The home had been involved in the Vanguard project through the local Clinical Commissioning Group. This is a national initiative to drive though improvements in health provision to minimise unnecessary hospital admissions. We spoke with one of the Vanguard team who said the home was very responsive to any recommendations the team made. Through this they had hosted and implemented a dementia care mapping workshop which helped providers to improve the provision of care for people living with a diagnosis of dementia by being aware of their experiences and whether improvements could be made to increase the quality of their life. The manager was hoping to link the induction programme with some of the findings from this to aid staff knowledge and confidence. One staff member told us how much they valued

the input of the staff from the Vanguard project and felt this had had a positive impact on the home as it had improved their understanding on how to support a person with dementia more effectively.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always being supported to transfer in the safest possible way with staff who were competent.