Care Quality Commission

Hailsham House (New Road) Limited

Hailsham House

Inspection report

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Hellingly
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Ratings

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

Overall summary

Hailsham House provides nursing care and accommodation for up to 87 people who live with a dementia type illness, for example Korsokoffs disease and Dementia with Lewy bodies or/and a mental health illness, such as Bipolar disease and Schizophrenia. The home also provided care and support for people with Multiple Sclerosis and Parkinson's disease and end of life care. The home was divided in to three units, each with their own lounge and dining areas. A separate building at this location accommodated up to 31 people who had a tenancy agreement for their accommodation and who received 24 hour personal and nursing care.

This unannounced inspection took place on the 19 November 2014. There were 111 people being supported at this time.

There was a registered manager at Hailsham House. 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 and associated Regulations about how the service is run.

Summary of findings

People spoke well of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

The delivery of care suited staff routine rather than individual choice. Care plans were computer generated with accompanying risk assessments to promote people's physical health. They were up to date and reflected people's physical changing needs. Care plans however lacked sufficient information on people's likes, dislikes, and how staff could meet their social and welfare needs. Information was not readily available on people's preferences on how they spent their time.

Not everyone we spoke with was happy with the food provided in the home. The dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink enough to meet their needs.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

Feedback had been sought from people, relatives and staff. Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, and consistently investigated and acted on.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from a registered nurse.

Despite the concerns we found, staff told us the home was well managed and there were good communication systems in place. These included handover sessions between each shift, regular supervision and appraisals, staff meetings, and plenty of opportunity to request advice, support, or express views or concerns.

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

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?

Good

Hailsham House was safe. Staff had received safeguarding training and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe.

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks.

Safe recruitment procedures were followed. There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

Hailsham House was not consistently effective. Whilst nutritional needs were regularly assessed, people were not always provided with support to maintain a balanced diet. Gaps were found in food and fluid charts.

Whilst staff understood the Mental Capacity Act (2005) and how it applied to their practice, we found people's rights were not always protected on one to one close monitoring.

Staff were well trained, supported, informed and supervised to carry out their roles effectively.

Staff recognised changes in people's health and made sure other health and social care professionals were involved when necessary.

Is the service caring?

Requires Improvement

Hailsham House was not consistently caring. People were positive about the care they received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences and social well-being.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any verbal interaction.

Is the service responsive?

Requires Improvement

Hailsham House was not responsive to people's social and mental health needs.

Summary of findings

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually. Some people were isolated despite being surrounded by people. People who remained in their bedroom received very little attention.

There was a robust complaint policy and procedure in place that ensured

People's complaints were investigated and responded to.

Is the service well-led?

Hailsham House was not consistently well led. People were put at risk because systems for monitoring the quality of the service delivery were not fully effective. Audits had not identified that people were left for long periods of time with no interaction or mental stimulation.

The home had a vision and values statement, and staff were clear on the home's direction but observed practices told us this was not being delivered consistently by all staff.

Staff told us that they felt supported by the management and worked as a team.

Requires Improvement

Hailsham 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 checked 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 November 2014 and was unannounced.

The inspection team consisted of six inspectors and an Expert by Experience (Ex by Ex). An Ex by Ex is a person who has personal experience of using or caring for someone who uses this type of care service.

Not everyone who lived in Hailsham House was able to share their experiences with us verbally so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 19 people, 11 visitors, 12 care staff, the registered manager and the deputy manager. We observed the care and support given by staff in the communal areas and looked around the home, which included bedrooms, bathing facilities, kitchen, the dining areas, lounges and garden.

We reviewed 20 care plans, the quality assurance audits pertaining to cleaning, medication, environmental and people's care, health and welfare document, such as medicine administration records. We also looked at the organisational policies together with general information available for staff such as safeguarding, infection control and medication administration policies.

Before our inspection, we reviewed all the information we held about the home. This included notifications of events that have affected the service, safeguarding alerts, incidents, accidents and deaths. We contacted social services and two GP's from the local surgery. We also had feedback from the community psychiatric nurses and a dietician who had visited the home. We used the information shared to assist our inspection.

At the last inspection in July 2013 we had not identified any concerns with the service.

Good

Is the service safe?

Our findings

Using the SOFI tool we saw that people responded to staff in a way that showed us they felt secure and safe in the home. We observed people approach staff when they were anxious and needed reassurance or direction. Visitors told us they felt Hailsham House was a safe environment and they felt confident that staff were trained and competent. Comments included, "They look after my husband expertly, I can relax knowing he is safe," "I feel blessed that my mum is here, it's not perfect, but she is safe and happy," and "My husband is comfortable and safe."

Staff had received training in safeguarding. It was clear that staff understood their responsibilities to keep people safe from abuse. They had a good understanding of the types of abuse and who they would report any suspicions or concerns to. The safeguarding adults at risk policy was available to staff. The policy supported staff to follow the protocols set by the local authority who lead on all safeguarding concerns. Staff told us that they would immediately inform the manager and call the local authority safeguarding team. Staff said, "I would not hesitate to raise a safeguarding if I felt someone was at risk," and "I've received safeguarding training. Any abuse or altercations between residents I report to the manager and social services."

The provider was able to p protect people from harm through systems that identified risk. Each person's care plan had a number of risk assessments completed. The assessments detailed what the activity was and the associated risk. For example, assessments related to mobility, depression, going out of the home, nutrition and individual specific health needs, such as pain relief, diabetes and incontinence. We saw that the guidance was specific to each person and was linked to their individual capability. Risk assessments were up to date and reviewed regularly which meant staff worked to the most up to date information about a person.

We asked how staffing levels were managed to make sure people were kept safe. The registered manager explained how they assessed people's dependency on a daily basis and if a person was distressed, agitated or had an outing or hospital appointment, additional staff would be brought in to meet people's individual needs. We were given examples of when extra staff had been brought in, such as for continuous one to one support. This had been required in recent months and it was clear from documentation provided that when a person had been unwell and needed more support it had been provided. Staff felt that the staffing levels were sufficient at all times to deliver a good standard of care. One staff member said, "We know who needs more supervision and we prioritise." Another staff member said, "We would request more staff if we felt it was unsafe." People told us, "There are staff on duty during the day and at night and they are always willing to help if you need their assistance," "I feel very safe and happy here, don't want to live anywhere else," and "Always someone to talk to, or help me." We saw that a call bell facility was available in the home. We were told, "If I need help I just ring and they come." For people who were not able to use a call bell staff had systems in place that ensured people were checked regularly. We saw that there were enough staff to provide care and support people safely.

The provider had appropriate arrangements in place for the safe management of medicines. We saw records of medicines received, disposed of, and administered. Nurses who administered the medicines carried out the necessary checks before giving it and ensured that the person took the medicine before signing the medication administration record (MAR) chart. We looked at everyone's MAR charts and found that recording was accurate and clear. Records showed people were given their medicines as prescribed. Medicine administration audits were conducted on a monthly basis and any anomalies recorded were followed up by senior staff. Staff were aware of the need to consult a GP if a person continued to refuse their medication. This was to ensure that any impact to their health was clearly understood.

People were cared for by staff that had been recruited through safe procedures. Each member of staff had undergone a criminal records check before starting work. We looked at staff recruitment files and saw that the provider had a robust and thorough recruitment process.

Staff received regular fire training and fire emergency evacuation training. There was fire fighting equipment placed around the home that had been recently checked and was ready for use. We saw that the fire emergency evacuation procedure was displayed throughout the home. The emergency plan had comprehensive policies relating to adverse events such as fire, utility failure, accidents and

Good

Is the service safe?

the outbreak of disease. The plan included the contact numbers of local services including doctor surgeries, home manager's out of hours contact details, emergency services and utility providers.

We looked at accidents and incidents records and audits. We saw accurate recording of incidents between people and these had been referred to social services and CQC in a timely manner. The audit and monitoring processes in place showed that the management team had fully investigated all accidents and incidents, and where appropriate had introduced an action plan or developed strategies to prevent a reoccurrence.

There was a clear process for managing any deterioration in mental health of people with emergency guidelines to follow, such as contact details of the community mental health team. Staff were able to tell us who they would contact in the event of a medical emergency and were aware of where to find contact numbers. Incident records were reviewed by the management on a monthly basis, or more regularly if a person's mental health deteriorated, or if there were arguments between people resulting in injury or psychological harm. An example was a recent safeguarding alert raised by the manager, which had resulted in a plan for increased monitoring of a person to prevent physical disputes.

Requires Improvement

Is the service effective?

Our findings

People told us, "My husband is okay here, I can relax knowing he is being cared for," and "I visit my mother regularly, so I know she is getting the care she needs." However, we found that Hailsham House did not consistently provide care that was effective.

The food was delivered in hot trollies to the units where staff served the food. Pureed food was attractively presented and recognisable as meat, vegetables and potato but prior to feeding people staff mixed the food together. People were then unable to identify the food they were eating. Much of the food was returned uneaten and poor appetite trends may not be picked up, as staff did not routinely record this unless it was someone identified at risk from malnutrition.

We observed the meal service on all four units. On two units people were encouraged to sit together at tables to eat their meal. The staff put the television on mute and there was soft music playing in the background. On all units whilst staff prompted and encouraged people to eat, there was little meaningful communication with people. Staff assisted with no eye contact or conversation and people were not invited to talk and so the meal was a solitary experience for people.

The meal service on two units was not an enjoyable experience for everybody. People were seated at dining tables which were uninviting as they had not been set for a meal. There was no visual stimulus that would have promoted it as being a mealtime. Nine people remained seated in the lounge area and either had small tables to eat their meal from, or received one to one support to eat. There were six staff and whilst people who needed support did get it, they had to wait, in some cases for 45 minutes before they got their meals. No-one was asked if they enjoyed the lunch, offered alternative choices to those that hadn't eaten, or asked if they wanted more or were still hungry. We observed a person was pushed to an empty dining table in a wheelchair. The brakes were left off and the person could not easily reach their meal. A staff member came over and started chopping up the food without asking if this was what they wanted. The person became angry and told the staff member to leave it. The staff member continued to cut up the food and the person hit out at the staff member. The staff member stopped, and another staff member came over and continued to cut the food until the person started to push themselves away from the table refusing to eat. The person did not eat and was not offered any alternative until we intervened. The person was offered a meal that had congealed. Finally staff arranged for a sandwich which wasn't eaten, therefore this person did not eat for eight hours.

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from dehydration and malnutrition. There were records on two units that were incomplete and not totalled, and therefore would not be an effective way of monitoring their health. One person required 1500 mls a day to maintain their health but over 2 days they received less than this. Output was not recorded and staff therefore would not know if this person was dehydrated. Food records for some people also demonstrated they ate very little and no other monitoring was in place.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed the Mental Capacity Act 2005 (MCA) with the registered manager and staff. They were knowledgeable about how to ensure the rights of people who were not able to make, or to communicate effectively their own decisions were protected. We looked at care records which showed that the principles of the MCA had been used when assessing an individual's ability to make a particular decision.

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. The recent Supreme Court ruling has meant that for people living in care homes, if they are not free to leave and subject to continuous supervision and control, they may be deprived of their liberty. We were informed by the manager that DoLS application were being made, and were being progressed. There were individual assessments for people explaining how their freedom may be restricted and what least restrictive practice could be implemented. However, we found that some people who were on one to one monitoring as requested by the local authority were not given any space or respite from the staff member. We observed them sitting shoulder to shoulder throughout the day and were told that at night a staff member sat by the

Is the service effective?

bed. **It is recommended that this is discussed with the DoLS team for advice or further advice is sought in relation to Dols as this was seen as very restrictive practice.**

People had an initial needs assessment when first admitted. The care plans were well recorded and contained clear instructions as to the health care needs of the individual. They included information about the needs of each person relating to their mental health, medication, communication and nutritional needs. Care plans were accurate and showed us that people were involved in the initial assessment and on-going reviews. Reviews were done monthly or more often if a significant change to health or behaviour occurred, for example an infection which affected the effect of their medicines. Where appropriate, specialist advice and support had been sought in relation to meeting people's needs and this advice was included in care plans. We saw advice from speech and language therapists, dieticians, and community mental health nurses. For example advice from a dietician about sugar free meals and drinks for those that had diabetes. Staff said they valued input from external health specialists and enjoyed learning from them. One said, "We can share learning from the specialists among the team, it then improves the care we give."

All the staff we spoke with told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Staff received an induction programme and ongoing training support. This gave them the skills to carry out their duties and responsibilities. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "The induction process gave me the skills I needed to provide care for people. I was paired with others so I could learn, it was so good and all at my own pace. It made me feel confident." Another said, "I feel that my English has improved so much with guidance from my colleagues." There was a wide range of specialist training available to staff in managing the complex needs of the people they cared for. Such as managing challenging behaviour, care of people with dementia and of specific mental health illnesses.

Supervision was up to date for all staff. Supervision had helped identify gaps in their knowledge, which was supported by additional training. Staff said "Supervision is really helpful, it gives me the opportunity to discuss anything, and I used it when one of the resident's behaviour scared me. I was able to get further support to manage the situations that arose." We were also told that for staff whose first language was not English that English lessons were provided.

Staff told us, daily handovers and supervision helped them feel supported and encouraged learning to take place. For example, handovers gave them an opportunity to discuss people's change in needs and anybody that was unwell.

Staff told us that they did have regular one to one meetings with their line manager; the staff folders showed us that staff supervision was undertaken regularly. Staff told us, "Supervisions are helpful because it gives us an opportunity to discuss anything that worries us and ask for training," and "It's always good to be able to discuss our career path, NVQs and other training."

One relative told us that they were regularly consulted on the care provided, included in the review process and were always kept informed about any changes as they occurred. Comments included, "My relative once had a tiny sore and they were on to it straight away and got rid of it. They spotted it immediately, "My husband has seen the SALT to discuss his swallowing and speech difficulties," "My relative gets to see the chiropodist, barber and the optician whenever he needs to."

We were also told "They have a system where everything is on line so every morning I log in and check how he is. It's just brilliant and gives you every bit of detail from toilet habits to how he is, to doctors' visits, everything. So you're completely up to date with every aspect of what's going on. I could even check on him whilst I was on holiday."

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they or their loved one received. Relatives told us, "They speak to residents, have a respectful approach, keep the place clean, and know their behaviours," and "My husband was always very fussy so it's right that he's always shaven and kept clean in his own clothes." However this was not fully supported by some of our observations

Some staff did interact with people in a caring manner, but we also observed instances when staff did not engage with people. Staff assisted people, but did not ensure comfort by verbal reassurance or display an empathy with people's mental health needs. We saw one person being continually sent away by staff when the person approached them. This person then sat alone and remained anxious.

Staff told us they promoted people's independence and respected their privacy and dignity. Staff knocked on bedroom doors and waited for a response before they entered. Staff also greeted people respectfully and used people's preferred names when supporting them. One staff member commented on how they encouraged people to be as independent as possible. However this was not supported by our observations. For example one person wanted to help staff by tidying up the dining room, but was asked to "Leave it alone." No explanation was given and this person became withdrawn and sat on their own. On another unit a person was restless. They told us they were looking for a quiet place to sit. Staff collected this person four times in one hour and took them back to the main busy communal lounge where they remained restless and anxious. This person's individual need was not considered or respected by staff at this time.

Our SOFI identified that on two units, verbal interaction was minimal and staff lacked empathy with the people they supported. The environment and atmosphere was unstimulating. We saw an example where a person was screaming and calling out constantly for over 35 minutes, but was ignored by staff. When asked staff said, "It's just them." On Orchard unit where nine people who had complex mental health needs were in the lounge area with two carers, seven people were dozing or totally disengaged. One member of staff was looking at a newspaper whilst sitting with one person and another sat with a person looking disinterested and disengaged. The staff member did not speak nor make eye contact with the person. There was little respect or consideration shown to these people.

Observations throughout the day identified that staff did not always offer people a choice or listen to what they wanted. People were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. The television was on in Holly lounge but people were not asked if that was what they wanted to watch. One person was asking to return to their bedroom but staff told them to stay in the lounge. This had not fully enabled people to make everyday choices important to them and to meet their identified needs. One member of staff told us, "We try to ensure that people are given choice and make decisions for as long as they can but many can't, so we do it for them." This did not promote people's independence or autonomy.

Suitable arrangements were not in place to ensure that peoples dignity privacy and independence were respected and that people were treated with consideration and respect. People were not supported to be able to express their views. These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were involved and consulted about their loved ones care plans. A relative said, "We were all involved in the development of a care plan. They check every so often it's alright." A further visitor said, "My father's care plan was all discussed with me and we have had a review to see how is been going. My father can't be involved so it's done with me. When he first arrived they asked me all about his likes and dislikes, his history and his capabilities.

People's needs in terms of their disability, race, religion or beliefs were understood and met by staff in a caring and compassionate way. Care records contained sensitive information about people's cultural needs regarding their end of life plans. Detailed notes explained exactly how staff would make sure a person's wishes would be respected. A senior member of staff told us that they had had training to be able to deal with specific religious practices. We received feedback from a family to say how pleased they were in the way the home respectfully carried out their relatives wishes in a dignified way.

Requires Improvement

Is the service caring?

The registered manager confirmed that where appropriate people were supported to access advocates. Advocates are used to speak on people's behalf to make sure decisions about care, treatment and support were made in a person's best interests. For example, a person had been assessed as lacking capacity to make the decision about how they could have their needs met. An independent mental capacity advocate (IMCA) had been used to determine how best the person could be cared for.

Friends and relatives were able to visit without restriction. The website and service users' guide detailed the service's open door visiting policy. It explained how the environment offered a choice for people to meet in the company of others, or in private. People told us they were supported by staff to have frequent contact with friends and relatives. One visitor stated; "You always get greeted and made to feel welcome and you can come at any time." A relative said; "We visit at all times of the day and are always made to feel welcome," and "Other relatives here gave me such great feedback when he came, so I gradually started to feel more reassured."

Requires Improvement

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. However, we found Hailsham House did not consistently provide care that was responsive to people's individual and changing needs.

Communication and social well-being was an area that we identified as a concern, as there were people isolated in the lounge areas and bedrooms with little interaction. People that were able to walk independently and able to communicate with words interacted with each other, visitors and staff. However, people who could not communicate were left for long periods of time without staff interaction. Staff were seen in the communal areas, but did not actively engage with people. We noticed one particular person who constantly wanted to be up and about and involved. This person approached care staff in a way that suggested they wanted some occupation, to be of use or at least have some engagement. However this was ignored and the person was consistently led back to a chair and encouraged to sit down. This happened four times in a one hour period with several different care staff having the same approach. Staff did not identify the individual's needs or show a caring attitude to this person. **It is a recommendation that the provider contacts the In-reach team for advice on staff communication strategies for people living with dementia.**

We spent six hours on Holly unit. The lounge and adjoining dining area initially had 11 people sitting in there. Many people were dozing and some had unopened books in front of them. The television was on but no one was watching it. The environment was stark, uninviting and unstimulating. For some of the time –two hours, both the television and background music were playing at the same time. Staff were not seen to have offered these activities to everyone. One staff member said "We know who will join in and who won't." During our discussion with staff it was clear that for those people who had not previously wanted to engage in activities, were not actively encouraged or offered further opportunities to join in. This meant that staff were not responding to people's individual changing needs.

Activities were planned and the programmes of activities were displayed in communal areas, but not everybody's social needs were being met. For example, three people on Willow unit were enjoying an arts and crafts session however there were 30 people on this unit, so the activity was not for everyone. No other activity was offered. People's care plans did not identify people's preferences or hobbies that they used to enjoy. The activity programme did not evidence people's preferences, for example, one relative told us, "My relative loved to listen to dance music, it's a shame that they haven't got any for them to listen to," and "Gardening, that's what would be nice."

On the first floor of Holly unit some people had high nursing needs and were on bed rest. We noted that apart from when care was being delivered, staff were rarely seen on this floor. One relative wanted her husband moved to the lower floor despite this meaning a much smaller room, they said "I was worried about him up there anything could have happened to him. He could have had one of his seizures and no one would have known as there is no one near or anyone around up there." This person had moved to the smaller room and his relative was reassured.

Another person was observed lying in bed staring at a blank wall. The room felt cold and the person was lying under an open window in a draught. Their door was shut, the curtains closed and music was playing on the radio. The care plan contained no information that the type of music playing was the person's preference. Staff therefore had not ensured people's individual welfare and social needs were being met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care records contained detailed information about people's health care needs. The home used a computerised care plan system, which was written from the person's perspective and reflected how they wished to receive their care and support. Records were clear and gave guidance to staff on how best to support people. They were regularly reviewed in order to respond to people's changing needs. Visitors told us they could access on line updates about their relative's care and so felt involved.

Individual physical needs were regularly assessed, so that care was planned to provide people with the support they needed to maintain their health. The manager informed us that staff were expected to not only identify problems during assessments, but be responsive in addressing them. For example, people whose swallowing was noted to be deteriorating was monitored and referred to a speech and

Requires Improvement

Is the service responsive?

language therapist. For people who had diabetes and were not eating enough, they were referred to the GP immediately for advice to avoid complications such as low blood sugar.

People were encouraged and supported to maintain links with their families to help ensure they were not socially isolated or restricted due to their disabilities. The home invited families and friends in to their home community for social events that were held.

The provider had a policy and procedure in place for dealing with complaints. This was made easily available. The policy was placed in each individuals service user pack and clearly displayed around the home. People knew who to contact if they needed to raise a concern or make a complaint. People who had raised concerns confirmed the issues were dealt with to their satisfaction. A relative told us; "I know how to complain, but I really don't see I would ever have a need to."

We looked at formal complaints made to the home. Each complaint had been responded to in a timely manner and thoroughly investigated in line with their own policy. Appropriate action had been taken and the outcome had been recorded and feedback. The registered manager told us, they used monthly audits to monitor concerns and complaints.

Appropriate action was then taken to improve their service and raise standards of care. For example, one audit highlighted several relatives had raised concerns around staff's ability to manage people's behaviour that challenged them. The registered manager had set up meetings and involved the relative. The idea was to raise awareness of how living with dementia can affect people and provide relatives with the knowledge required to help understand people's behaviour and staff's actions. As a result concerns raised around staff practice had been reduced and staff felt more competent in their role.

Requires Improvement

Is the service well-led?

Our findings

People, friends and family and staff all described the management of the home to be approachable, open and supportive. People told us; "Always available and very approachable." and "So understanding and ever such a lot of help." A relative said; "The management have time for you, they will stop and talk and most importantly listen." A staff member commented; "The management are supportive, they come out onto the floor, they're not just stuck in their office."

Whilst there were quality assurance systems in place they had not identified that people's social and welfare needs were not being consistently met. We identified throughout the inspection that many people were unstimulated and isolated at times. Staff did not actively engage with people. However we understood that many oversea staff were attending English classes and that in time this will improve the interaction and communication between people and staff. We also found that people's nutritional needs were not being effectively managed and monitored to ensure that people had enough to eat and drink. These areas had not been identified through the provider's quality assurance systems.

The provider and management team inspired staff to provide a quality service. Audits were carried out in line with policies and procedures. Areas of concern had been identified through these audits and changes made so that quality of service was continually improving. For example cleanliness, medication management, and equipment. We saw however that audits did not extend to holistic care. They had informed us, and the registered manager confirmed the service measured their performance against recognised quality assurance schemes. These included six steps, an end of life care strategy programme, dementia quality mark and investors in people. However as observed during our inspection this was not fully embedded. This was an area that requires improvement.

The provider, the registered manager and the deputy manager took an active role within the running of the home and had good knowledge of the staff and the people. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

The registered manager told us one of their core values was to have an open and transparent service. The provider sought feedback from people and those who mattered to them in order to enhance their service. Friends and relatives meetings were regularly held and surveys conducted that encouraged people to be involved and raise ideas that could be implemented into practice. For example, relatives had been involved in the changing of two units into one and had made helpful suggestions. People had meetings to discuss specific topics. For example, meals and activities within the home. People and relatives told us they felt their views were respected and had noted positive changes based on their suggestions.

Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice. If suggestions made could not be implemented, staff confirmed constructive feedback was provided. For example, one staff member told us they had recently questioned the necessity to complete certain forms during their working day. They said; "I felt listened to, although the process could not be changed, the manager fed back why and I now I have a better understanding behind the reason we need to do certain things." Another member of staff commented; "I raised a concern, the manager took my comments on board, spoke with staff and I've noticed change already."

Information following investigations were used to aid learning and drive quality across the service. Daily handovers, supervision and meetings were used to reflect on standard practice and challenge current procedures. For example, the use of bedrails. This had led the home to use low profile beds and not use bedrails.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs. **Regulation 9** (1) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration. **Regulation 14 (1) (a) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not ensured the dignity and privacy of the service users or enabled them to participate in making decisions relating to their care. **Regulation 17 (1) (a) (2) (A) (c) (g)**