HC-One Limited

Brandon House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 May 2017 and was unannounced.

Brandon House Nursing Home provides dementia nursing care for a maximum of 35 people. On the day of our visit there were 31 people living in the home. The home has two floors each with its own communal and dining area.

A registered manager was in post. 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.

During our last inspection undertaken on 12 November 2014 we found inconsistencies in people's records regarding their mental capacity. During this visit improvements had been made and this meant the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Consent to care was sought in line with legislation and guidance. Mental capacity assessments had been completed and where people had been assessed as not having capacity, best interest decision meetings had taken place and the outcomes were clearly recorded.

People told us they felt safe living at Brandon House Nursing Home. However, people's family members and the staff felt on occasions there were not enough staff available to keep people as safe as possible.

Procedures were in place to protect people from harm. Staff had a good understanding of what constituted abuse and staff refreshed their knowledge by completing safeguarding training. Risks associated with people's care were identified. Detailed information for staff to follow to reduce risks and to keep people safe when delivering care was not always consistently recorded.

Some people were at risk of dehydration or malnutrition. However, we could not be sure those people had received sufficient nutritional intake as quantities being consumed were not being accurately recorded.

There were processes to keep people safe in the event of an emergency. Incident and accident forms were completed. Information was analysed and action was taken to reduce the likelihood of the incidents happening again.

People's family members spoke positively about the way their relation's medicines were administered by the trained staff.

The provider's recruitment procedures minimised, as far as possible, the risks to people's safety. New staff members received effective support when they first started working at the home and staff received regular training which supported them in meeting the needs of people living in the home effectively.

Staff had their work performance monitored through one - one meetings with their manager. Staff had opportunities to attend and contribute to monthly team meetings. The provider had a process for recognising individual staff member's commitment and hard work.

We received mixed feedback from people regarding the food and drink that was available to them. The lunchtime experience upstairs was positive for people. However, downstairs people were not always supported effectively to eat or to enjoy their meal. However, staff demonstrated a good knowledge of people's nutritional needs and their dietary requirements. People received the appropriate health care to meet their needs.

The home had a contract for seven discharge to assess short term placements which were funded by the CCG (Clinical commissioning group). Staff knew the people they cared for well. Staff behaviours and attitude to their work showed they wanted to look after people who were in their care well. However, staff were busy and they did not have as much time as they would like to spend with people. Staff tried to be responsive to people's needs and tried to ensure people's requests were met in a timely manner but sometimes people had to wait for assistance.

People were treated with kindness by individual staff members and positive interactions took place between the staff and the people who lived at the home. Staff showed concern for people's wellbeing and knew what support provided comfort to people when they became anxious.

People were treated with dignity and staff demonstrated their commitment to continually supporting people to maintain and regain their independence.

Some people were stimulated with activities at certain times of the day during our visit. People did not always have opportunities to maintain links with their local community.

Since our last visit the provider had made further improvements to the environment to 'brighten up' and provide more stimulation for people living with dementia. Plans were in place to improve the outdoor garden environment for people. However, it was not clear how people had been consulted on how the area should look.

People were supported to make choices and decisions about their everyday routines. People were encouraged to maintain relationships important to them. People's family members felt well informed about their relation's changing needs and felt involved in decisions about their family member's care and support.

We looked at a selection of care plans which contained people's life stories. However, some plans contained conflicting information and another did not clearly reflect when a person's needs had changed.

People and their family members told us they knew how to make a complaint if they wished to do so. They were actively encouraged to put forward their suggestions and views about the service they received and the running of the home. However, they did not always feel confident actions would be taken in response to their feedback.

There was a clear management structure in place at the home. People and their family members had mixed views regarding the leadership of the home. Staff felt supported in their roles and spoke positively about the registered manager. The registered manager had worked hard to improve the culture and encourage team working at the home since our last inspection. However, some staff did not always feel valued by the management team.

We saw good examples of team work and communication between the staff and the registered manager during our visit. The registered manager chose to have a 'hands on' approach so they worked alongside the staff team and got to know people who lived at the home well.

There were systems to monitor and review the quality of the service. The management team completed regular checks of different aspects of the service. However, we could not be sure all of the checks were always effective such as, audits of people's care plans.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe and procedures were in place to protect people from harm. People's family members and the staff felt on occasions there were not enough staff available to keep people as safe as possible. Risks associated with people's care were identified but information for staff to follow to reduce risks was not always consistently recorded. Incident and accident forms were completed and analysed and action to reduce the risk of incidents happening again was taken. The provider's recruitment procedures minimised the risk to people's safety. The provider had taken measures to minimise the impact of unexpected events.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was compliant with their responsibilities in relation to the Mental Capacity Act (2005) and where people lacked capacity to make decisions, action had been taken to ensure they were appropriately supported. New staff received an induction and all staff were supported to develop their knowledge and skills to meet people's needs. We received mixed feedback from people regarding the food and drink that was available to them. The mealtime experience was not positive for all people. Staff demonstrated knowledge of people's nutritional needs. People who lived at the home received the appropriate health care to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and positive interactions took place between the staff and the people who lived at the home. Staff knew the people they cared for well and people were supported to make choices and decisions about their everyday routines. People were treated with dignity and the staff demonstrated their commitment to continually supporting people to maintain and regain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always responsive to people's needs. Some people were stimulated with activities at certain times of the day during our visit. Some care plans contained conflicting information and another did not clearly reflect when a person's needs had changed. People and their family members knew how to make a complaint if they wished to do so. They were actively encouraged to put forward their suggestions and views about the service they received and the running of the home. However, they did not always feel confident actions would always be taken in response to their feedback.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was clear leadership of the home. We received mixed feedback from people and their family members about the home was run. Staff told us the manager was approachable and they felt supported in their roles. Audits and checks were completed to monitor and review the quality of the service. These checks were not always effective. People, family members and staff were encouraged to give feedback about the quality of service provided within the home.

Brandon House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 31 May 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor was a specialist dementia nurse. The expert by experience was a person who had personal experience of caring for someone who had similar care needs to people living at Brandon House Nursing Home.

Prior to our visit we reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke with local authority commissioners who funded the care some people received. They were happy with the care provided to people.

During the visit we spoke with two people who lived at the home. Other people were unable to tell us about their experience of the care. We therefore spent time observing how they were cared for and how staff interacted with them so we could gain a view of the care they received. We also 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 were not able to talk with us.

We spoke with three people's family members. We also spoke with the registered manager, one nurse, three nursing assistants, four care workers, the chef and one activities coordinator.

We looked at the records of six people and two staff records. We looked at other records related to people's care and how the home operated. This included checks the management team took to assure themselves

that people received a good quality service.

Following our visit we spoke by telephone with the family members of a further two people to gather their views on the service people received.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Brandon House Nursing Home. However, we received mixed feedback from people's family members. One explained their relation was at risk of falling out of bed and they were happy with the prompt action the staff had taken to obtain a piece of equipment to reduce the risk. Another told us they thought during the night time there were not always enough staff on duty .This on occasions had made them feel worried about their family member's safety. They said, "It is a bit of a worry, the staff are very busy, needs are high and I do worry there is not enough of them to cope."

When we asked staff if there were enough of them to keep people safe, we received mixed feedback. Comments included, "Most of the time there is enough of us." "Sometimes there is and sometimes there isn't. They do try and get cover but it is not always possible." And, "I think we need more especially during the night. We just manage but it would be helpful to have more because then we would have more time for more people." This meant because people lived with dementia it could be difficult for the staff to supervise them to always ensure their safety. Following our visit in response to this the registered manager informed us the home had introduced a 'twilight shift' between the hours of 8 and 10pm which increased the level of staff on duty from four to five during the evening.

We discussed staffing levels with the registered manager. They assured us there were enough staff on duty in line with the provider's policy to keep people safe and at the time of our visit there was only one staff vacancy. The use of agency staff had also reduced over the few months prior to our visit. They explained it was an, 'on-going struggle' to recruit qualified nurses. They told us trained nursing assistants were employed to assist the qualified nurses and the way staff were deployed in the home was under constant review to ensure people were kept as safe as possible.

Procedures were in place to protect people from harm. We saw the provider's safeguarding reporting procedure was displayed in communal areas of the home to inform people how to report if they felt unsafe. Our discussions with the registered manager confirmed they were aware of their responsibilities to keep people safe and any allegations of abuse were reported correctly.

Staff confirmed they had completed safeguarding training to obtain the knowledge they needed to keep people safe. Training included how to raise concerns, and the signs to look for such as unexplained bruising to the skin, which might indicate people were at risk. Staff described to us their responsibilities to keep people safe and they told us they were confident to report any concerns to their managers. We asked staff what they would do if action was not taken to investigate their concerns. They told us they would contact the provider's whistleblowing helpline. A whistle blower is a person who raises concerns about poor practice in their workplace. One staff member told us, "If I felt the manager wasn't doing something, I would use the whistleblowing line. I would report it higher because we are here to look after people this is their home."

Risk assessments and management plans identified potential risks to people's health and wellbeing. However, information for staff to follow to reduce risks and to keep people safe when delivering care was not always consistently recorded.

For example, one person had sore skin which at times meant they were in pain. We saw clear plans and guidance for staff were in place to manage this risk. The person had an airflow (pressure relieving) mattress in place. Staff repositioned the person every few hours to relieve the pressure on the skin they were sitting or lying on. Records showed staff had followed the guidance and the condition of the person's skin had greatly improved in the two months prior to our visit.

Another person became anxious and at times displayed behaviours that could cause distress or harm to others. To reduce this risk one-one care from a member of staff was provided. We saw the staff member positively engaged with and occupied the person throughout our visit which reduced their anxieties. We spoke with this staff member and they were knowledgeable about the risks. However, clear guidance was not recorded to help them to manage or reduce the risk.

A third person was at high risk of falls. At the time of our visit they were in hospital because they had fallen and had been injured. Their risk assessment informed staff the person could become anxious which increased their risk of falling but no clear guidance was available to help staff manage or reduce the risk. Despite this, our discussions with staff assured us they knew who was at risk of falling and they knew how to manage the risks. One said, "I know the people who are prone to falls and we make sure the environment is clear and we keep an eye on them." Another said, "There has to be a member of staff in the lounge and you have to have two people on the floor at all times." We observed throughout our visit staff were present to supervise people in communal areas.

We discussed our findings with the registered manager and they acknowledged further detailed information to manage and reduce risks needed to be available to the staff team. Following our visit they confirmed this had happened.

There were processes to keep people safe in the event of an emergency and equipment that would be needed in an emergency situation was accessible to the staff team. People had personal fire evacuation plans so staff and the emergency services knew people's different mobility needs and what support and equipment they would require to evacuate the building safely. A service contingency procedure was in place and was on display in communal areas of the home. Therefore, if there was disruption within the home due to an unexpected event people should receive continuity of care.

The provider's recruitment procedures minimised, as far as possible, the risks to people's safety. The registered manager explained the service recruited staff who were of good character and checks were carried out before they stated work. Staff confirmed their references had been requested and checked and they had not started working at the home, until their disclosure and baring (DBS) clearance had been assessed by the provider. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

We looked at how medicines were managed by staff at the home. A relative spoke positively about the way their family member's medicines were administered by the staff. They said, "Yes (Person) does get his medicines on time, and they (staff) get him to take them." Another told us, "Yes, I think medicines are managed well." Only trained staff administered people's medicines. Staff confirmed they had received training, and a manager observed their practice to make sure they were competent to do so.

Some people were prescribed 'as required' medicines to manage their pain. These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. Protocols (medicine plans) for the administration of these medicines had been implemented to make sure they were administered safely and consistently. This was important if a person was unable to inform staff of

their pain. We asked staff how they knew if someone who was unable to tell them was in pain. One said, "It would be obvious by their facial expressions."

The provider had a procedure for recording and monitoring accidents and incidents. Accident and incident records were completed and were up to date. The registered manager analysed and shared their findings with the provider each month. The analysis included falls and the reasons for the falls to try and identify any patterns or trends to reduce further falls happening. Staff told us the ways to reduce falls had been discussed during staff meetings. Some equipment had also been implemented to prevent people falling. For example, a sensor mat had been put into place to alert staff if the person got out of bed so they could offer prompt assistance.

Equipment used by people was checked by staff and external contractors to make sure it was safe to use. A maintenance person worked at the home to undertake general repairs and complete safety checks. For example, on the day of our visit the weekly fire alarm test took place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

During our last inspection on 12 November 2014 we found inconsistencies in people's records regarding their mental capacity. Some records contained detailed information but others were not completed correctly. This meant it was not clear what decisions people could make for themselves. During this visit we found improvements had been made. This meant the provider was working within the principles of the MCA and conditions on authorisations to deprive a person of their liberty were being met.

The registered manager understood their responsibilities in relation to the Act. All of the people who lived at the home had been assessed to determine whether they had capacity to make their own decisions. Where people had been identified as not having capacity to make specific decisions about their care, appropriate discussions had taken place with those closest to the person to make decisions in their best interests. The outcome of these was clearly recorded. The Act requires providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The registered manager was aware of this process and we saw applications had been submitted and authorised where restrictions on people's liberty had been identified. For example, some people were unable to consent to their care.

Staff had received MCA training and the majority of staff demonstrated to us they understood the principles of the Act. They gave examples of applying these principles to protect people's rights, such as, asking people for their consent. We saw staff asked people for their consent before providing assistance. For example, one staff member asked a person, "Shall I help you with your drink?" We asked staff what they would do if a person declined assistance with their personal care. They told us, "Sometimes [person] won't let you help them so we just back away and try again a little bit later." And, "I would ask someone else to help them; we can't force them [people]."

New staff members received effective support when they first started working at the home. One new member of staff told us they had completed computer based training before they had started work. Their induction had also included working alongside experienced staff to see how people preferred their care and support to be delivered. Completion of the induction ensured staff understood the provider's policies and procedures and meant they had received training in-line with the Care Certificate. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected. This demonstrated the provider was acting in accordance with nationally recognised guidance for effective induction procedures to ensure people received good care.

Staff told us they received regular training updates which included health and safety and fire safety training. Most training was e-learning, and staff completed competency tests to demonstrate their learning which was then signed off by the registered manager. One commented, "The training is good. We do the 'touch training' and you can go and do different types of training." Another staff member explained they had been supported to do further external training in areas such as health and safety, diabetes and dementia to meet the specific needs of the people who lived in the home. The training schedule in use showed us the majority of the staff training was up to date, when training had been completed and when it was next due. This helped the management team prioritise and plan training the staff needed.

The staff team also had opportunities to complete qualifications such as, social care diplomas. Most care staff had completed or were working towards level two or three qualifications in health and social care. This ensured they had the skills they needed to meet people's needs.

The registered manager was an accredited trainer and was qualified to provide some training to the staff team which including moving people safely. They told us, "It's a good way for me to make sure all staff are well trained." We saw staff put their training into practice. For example, during our visit we observed two staff members use a piece of equipment to safely move one person from an armchair into a wheelchair. Staff interacted with the person and explained to them what they were doing. The person responded well to this by smiling.

The provider had introduced a new nursing assistant role into the home to ensure people's needs were continually met by a skilled and knowledgeable staff team. Some existing senior care workers had completed extra training such as, catheter care and end of life care to increase their skills to be effective in the role. They explained they had spent time working alongside the nurses which had made them feel overall, more confident. One said, "The nurses have been great with us and anything you are unsure of you go to them." However, some staff we spoke with did not feel the role was effective. Staff were concerned the pressure placed on the nursing assistants was too high and this had a negative effect on staff morale. We discussed this with the registered manager and they assured us they were working with the staff team to ensure the purpose and responsibilities of the role were fully understood.

Handover meetings took place at the beginning of each shift when the staff on duty changed. Staff discussed the health and well-being of each person living at the home. A 'flash meeting' also took place each day. During these meetings staff shared information about the home. These meetings meant staff passed on and received important information such as, how people were feeling and if they had any planned appointments.

We received mixed feedback from people regarding the food and drink that was available to them. Comments included, "I don't enjoy the meals much, and it's nearly always chips." "I like the food," and, "The food is okay." In response to this the registered manager explained a variety of food choices were available to people and on occasions the chef did cook chips for people who had not requested them. However, when people saw the chips they often chose to have some to accompany their meal.

A family member assured us their relation did get enough to eat but they were not always offered choices and menus were not always provided. Following our visit we were informed this issue had been discussed and resolved at a recent meeting. Action had been taken to ensure menus were available to people.

We observed the lunch time experience in both of the dining rooms during our visit. The experience upstairs was positive for people. People were given visual choices of meals and they were provided with adapted cutlery so they were able to eat their meals independently. One person commented, "Mmm that looks

good", when they saw their meal.

However, in the downstairs dining room we saw people were offered verbal choices but no visual choice of the food to help people who found it difficult to understand verbal options make a decision. We also saw people were not always supported effectively to eat or to enjoy their meal. For example, a member of staff placed a meal in front of one person and cut up the person's meal on their request. However, the portion of food was too large for the plate and as the person began to eat the food spilt onto the table, into the person's lap and onto the floor. The person then spilt their drink. A member of staff cleaned up the spillages but did not engage with the person or offer them any reassurance or further assistance.

Staff we spoke with, including the chef, demonstrated a good knowledge of people's nutritional needs and their dietary requirements. For example, they knew who had diabetes, who needed encouragement to eat and who was at risk of choking. One person required their drinks to be thickened. Staff knew this and explained in detail how much thickener they needed to add to fluids to reduce the risk of the person choking. However, another person whose needs had recently changed required their meals to be liquidised. Staff knew this but it was not reflected in the person's care plan. Following our visit the registered manager confirmed the person's care records had been reviewed and updated.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment process. Some people needed their food and fluids monitored to ensure they consumed enough to maintain their health. Staff were required to record what everyone who lived at the home had eaten and drank. A staff member said, "We write down what everyone has consumed, it is very time consuming and isn't the best use of our time."

We looked at a selection of completed 'food and fluid' charts and saw they were not always correctly completed. For example, staff had recorded 'pudding' 'dinner', or 'ate all,' but had not documented the amounts people had consumed. Therefore, we could not be sure certain people had received sufficient nutritional intake. We discussed this with the registered manager and they told us it was the provider's policy to record nutritional intake for everyone who lived at the home because they all received nursing care. They assured us they would discuss this with the senior managers within the organisation. Following our visit the registered manager provided us with information to assure us nearly all of the people who were at risk of dehydration or malnutrition had either recently gained weight or their weight was stable.

People's records showed us how the home's staff worked in partnership and maintained links with health professionals. For example, one person who had lost weight had been referred to a dietician in December 2016. Staff had followed the advice provided but the person had continued to lose weight. A further referral was made In January 2017. This demonstrated the home had been proactive and had taken action to follow up their concerns. This meant people who lived at the home received the appropriate health care to meet their needs.

Good

Is the service caring?

Our findings

Staff told us they provided a caring service. Staff behaviours and attitude to their work showed they wanted to look after people who were in their care well. We saw people were treated with kindness and positive interactions took place between the staff and the people who lived at the home. We spent time in communal areas and observed staff were always present. We saw some staff knelt down to talk with people so they were on the same level as them and people responded well to this and engaged in conversations.

All the staff we spoke with showed concern for people's wellbeing. They told us the support people received was always delivered to a high standard. Comments included, "We are like a family really." And, "It is very caring and family orientated. At the end of the day, it is their home." The registered manager felt confident all of the staff were committed to providing high quality care to people.

Staff demonstrated they knew the people they cared for well. They explained they talked with people and their families' to find out 'all the small things' that were important to them. Staff also watched people's body language to find out what they liked and disliked if people were unable to tell them. Staff said this helped them to gain an understanding of how people wanted their care to be provided. Staff told us they worked on both floors of the home and this enabled them to understand the needs of everyone who lived in the home.

Staff knew what support provided comfort to people and we saw appropriate distraction techniques were used when people became anxious. For example, one person became tearful and staff promptly provided reassurance and spent time with the person painting their fingernails. We saw this reduced the person's anxiety. One staff member explained some people become anxious and confused due to their dementia. They told us it was important to approach people in an empathetic way. They commented, "I find if you have a smile and approach them [people] calmly, it makes them happy."

People were encouraged to maintain relationships important to them and family members told us there were no restrictions on visiting times. One relative said, "I can come whenever I like, there are no restrictions." They explained this made them feel welcome.

People's family members confirmed they felt informed about their relative's changing needs and overall, they felt involved in decisions about their care and support. One told us, "They do ask me my opinions, which is good." However, the relative had not been invited to any formal meetings to discuss their family member's care.

Staff recognised the importance of ensuring people's relatives felt involved in their family member's care. One said, "Whilst they are here I will go in and ask if they are okay and if they need anything. I make them feel welcome and let them know if they have any concerns, I am always there if they need to talk."

Overall, family members felt staff were kind and their relations were treated with dignity and respect. One told us, "Yes (Person) is treated with respect and dignity as far as I can see when I'm here; (Person) is always cleanly dressed when I arrive." However, another relative explained that often when they visited their

relation was wearing clothing which belonged to someone else. They told us they found this upsetting and they had already bought this to the attention of the registered manager who was in the process of resolving the issue.

People were supported to make choices and decisions about their everyday routines. We saw a person was wearing a dirty jumper in the lounge. A member of staff told us this was the person's normal routine and they would often accept help to change their jumper later on in day before their family member visited. We saw staff attempted on several occasions to provide assistance before the person then approached them for assistance which was then provided. A staff member told us, "We wait until they are ready for help otherwise they can get necessarily upset."

Since out last visit, staff had undertaken further training in meeting the needs of people with dementia and how to promote their dignity. The registered manager told us some staff had completing a training course to become 'Dignity Champions' at the home. The purpose of this was to gain a greater understanding of how people's dignity was being maintained and to make best practice recommendations to staff to benefit people living at the home. We saw information which emphasised the importance of people's privacy and dignity was on display in communal areas of the home. We saw staff knocked people's bedroom doors and waited for permission before they entered. This showed they resected people's right to privacy.

We saw the importance and the meaning of dignity had also been discussed at a recent team meeting. Staff had described they maintained people's dignity by respecting their feelings and covering them up when they were changing their clothes.

The staff team demonstrated their commitment to continually supporting people to maintain and regain their independence wherever this was possible. We observed staff doing this throughout the day. For example, they gently reminded people to take their time when they were walking along corridors. Staff also encouraged people to wear their spectacles so they could see where they were walking which meant people were less reliant of staff to guide them.

Requires Improvement

Is the service responsive?

Our findings

We observed staff tried to be responsive to people's needs and attempted to ensure people's requests were met in a timely manner. However, this was not always possible because staff were busy and this meant some people had to wait. One person told us they had asked a staff member for a drink at approximately 10am and they had not been given one until they had their meal at lunchtime over two hours later. A family member explained drinks were available and a 'tea trolley' offered drinks and snacks a few times each day but not everyone was able to help themselves outside of these times because they needed assistance from staff to help them move.

We asked staff if they had time to sit and chat with people to get to know them. They told us because they were busy they did not have as much time as they would like to do this. Our discussions confirmed they were able to meet people's care needs but because of the high dependency care needs of a few people and the high amount of paperwork they had to complete this took them away from spending time with people. One staff member told us, "We have up to ten pieces of paperwork per shift to complete per person." Another said, "It takes up so much time. If we weren't doing all that paperwork, we could be doing more with the residents." However, they assured us meeting people's needs took priority over completing paperwork.

The registered manager acknowledged completing the provider's paperwork was time consuming for the staff. They assured us they would discuss this with the senior managers within the organisation to see if the amount of paperwork could be condensed to reduce the time staff spent completing this task.

Staff told us their biggest challenge was being responsive to people's needs due to the amount of time they spent with the people who were on short term placements. Most of these people had high and complex needs associated with their dementia. One staff member told us, "The D2A (discharge to assess placements) put a lot of pressure on us." Another said, "We can't always meet their needs but there is nowhere else for these people to go so they stay here with us. It is really hard at times and means some people miss out."

The home had a contract for seven discharge to assess short term placements which were funded by the CCG (Clinical Commissioning Group). The placements were for with people who were fit for discharge from hospitals but their future care needs were not yet determined. Their placement at the home should not exceed 12 weeks and during that time social workers sought an alternative long term care provision. However, the registered manager told us that on occasions these people's needs were higher than had been expected because obtaining information to gain a clear understanding of a person's needs had proven difficult. Also, people often exceeded their short stay at the home because finding suitable long term placements in the local area was difficult. They acknowledged staff spent a lot of time supporting these few people and recognised this could impact negatively on other people who lived at the home.

We asked what action they had taken to resolve this issue. They said, "I have raised it higher with my managers and shared my concerns with the hospital and the council but it remains difficult to find long term placements to meet people's needs. We are in limbo." They explained the contract for the placements was currently under review and they were in discussion with their senior managers regarding the difficulties and

challenges associated with meeting the needs of people on short term placements.

From our observations and discussions with staff it was clear they knew people well which helped them to provide personalised care to in line with people's preferred routines and preferences. For example, one person enjoyed football and we saw they played a game of football with staff in the corridor of the home. We asked if this person had the opportunity to go into the garden area to play football because we were informed goal posts had recently been purchased. A staff member said, "Sometimes but if we go off the floor it can leave us short."

Another person liked to read and on the day of our visit they went to a local shop with a staff member to purchase a newspaper. A member of staff told us another person often felt cold. We saw the person had been provided with a blanket during our visit to keep them warm. Another staff member described how they supported one person who had previously travelled around the world. They said, "It is nice to talk with (Person) about the places they visited whilst travelling." Another said, "It is nice to know their history so when we help them we can chat with them about things they know."

Memory boxes were located on the wall outside of people's rooms. They contained photographs and things that the person enjoyed. For example, one person liked cars and their memory box contained a small replica model of their favourite car. Staff told us the boxes served two purposes. One was to help people to locate their bedrooms so they were not reliant on staff to help them and the other was for them to know what people liked so they could 'spark up conversations'.

People's family members and staff told us on occasions life within the upstairs floor area of the home could be noisy and they had seen people became agitated when noise levels were high. Only one communal room was accessible to people on the first floor and it's where people spent most of their time. A smaller 'quiet room' was also situated on the first floor but people were unable to access it because a coded lock was fitted to the door. We spoke with staff about this and they told us some people would benefit if they spent time in the quieter room because noise could increase their levels of anxiety. However, because a staff member needed to present in communal areas at all times it was not possible for the room to be unlocked.

A keyworker system was in place which meant people received continuity of care. Staff told us because people had named workers it made it easier to share and gather important information to ensure they remained happy and their needs were met. However, two family members we spoke with did not know who their family member's keyworker was. One commented, "I haven't got a clue."

We saw some people were stimulated with activities such as completing word searches and watching television. Other people were occupied with twizzle muffs. A twizzle muff is a hand muff with different items attached such as, beads, zips and buttons to provide stimulation which can have a calming effect on a person who has dementia.

However, at other times we saw people were not engaged or stimulated in any activities. Family members told us a variety of entertainment took place which their relatives enjoyed. Photographs of recent events were on display. We saw people, their family members and the staff had participated in events which had included St Patrick's and Valentine 's Day celebrations. We spoke with an activities coordinator. They said, "My role is activities, events planner and fundraiser, I enjoy my role. The best part of my job is seeing smiles on resident's faces during events and activities." We asked how they planned and provided activities for people who lived with dementia. They said, "I have had some training and I provide one- one activities for people in bed."

Since our last visit the provider had made further improvements to the environment to 'brighten up' and provide more stimulation for people. For example, brightly coloured flowers and murals had been added to the walls in the corridors. A small seating area with an 'outdoor garden' theme was available to people who lived upstairs. Staff told us some people enjoyed sitting and relaxing in the garden area which was beneficial to people's well-being.

An activities co-ordinator told us of their future plans to improve the outdoor garden environment for people. They were in the process of transforming an area of the garden into a beach. They said, "We will have brightly coloured deck chairs and real sand to stimulate people senses." However, it was not clear if people had requested this or whether people had been consulted on how the 'beach area' should look.

The provider's information brochure for the home stated, "There's plenty to do outside the home too, and our specially adapted minibus takes residents on trips to nearby places of interest to them, such as animal sanctuaries, the theatre, gardening and shopping centres.' However, family members told us their relation very rarely had the opportunity to go outside of the home and maintain links with their community. One said, "Its false advertising really, (Person) hasn't been out for over 12 months, they would love it but there is just not enough staff to take them." In response to this the registered manager informed us they had previously been unable to recruit a staff member to drive the minibus. However, shortly after our visit a staff member had been recruited. Some community outings had taken place such as, a visit to a local school to watch a play and visits to local shops. More community outings were in the process of being arranged.

We looked at a selection of care plans and saw people's life stories were documented such as, their happy memories, school life and interests. People's preferences and preferred routines were recorded. One person's favourite drink was hot chocolate and records showed us this person had been provided with this drink every day in the week prior to our visit. Other care plans contained conflicting information. This meant it was not always clear what specific support people needed from the staff. For example, one person did not speak fluent English. Their care plan stated, 'Difficulty with English on occasions.' However, it also advised staff 'speech is clear.'

A person's family member explained their relation's health had deteriorated in the 12 months prior to our visit. We saw the information documented in their care plan did not clearly reflect their needs. Information advised staff the person was fully mobile. However, we were made aware the person was cared for in bed. Despite this staff knew the person well. They explained the person was often in pain so they had to careful and gentle when they provided care. We discussed this with the registered manager who told us the nurses and nursing assistants were responsible for reviewing and updating people's records. They assured us the person's care plan would be rewritten immediately. Following our visit they confirmed this had happened.

Staff told us they tried to read people's care plans but this depended on how busy they were. They assured us they would report any changes in people's health or anything that could affect their wellbeing to the nurse or registered manager.

Group meetings involving people who lived at the home and their family members were held regularly. The dates of planned meetings were on display so people knew when to attend. People and their family members confirmed the meetings were well attended because they coincided with an event such as 'wine and nibbles' and, 'quiz nights'. We received mixed feedback about the meetings. One family member said, "The meetings are good." Another explained the meetings were often short in length which meant they did not always get the opportunity to have their say. A third told us, "I have never seen any minutes to make sure what we said is recorded." A meeting took place on the day of our visit and we were provided with the minutes. We found they contained some information on what had been discussed and what actions had

been agreed.

People and their family members told us they knew how to make a complaint if they wished to do so, which included speaking to the registered manager who they found approachable. However, they did not always feel that their complaints were responded to well. One relative explained they had raised an issue relating to the quality of care their family member received. They said, "Often the managers response is 'it's company policy' so really that means, like it or lump it ."

We saw the provider's complaints procedure was displayed in the entrance hall of the home. It contained information about external organisations people could approach if they were not happy with how their complaint had been responded to. We looked at the records of complaints for the 12 months prior to our visit. We saw four complaints had been recorded and all had been resolved to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People and their family members provided mixed feedback regarding the leadership of the home. Comments included, "The Managers Okay, I don't have much contact with her," "The manager seems nice," and, "I like the manager but their hands are tied by corporate policies." The relative said this made them feel frustrated because on occasions the service did not feel personalised. They added, "I know they have to have 'blanket' policies but sometimes they don't always work."

Staff spoke positively about the registered manager. One said, "She is nice. She is firm but she is fair." Another told us, "I do like (Registered manager) she is one of the best managers we have had." A third staff member explained how, since our last inspection, the registered manager had worked hard to improve the home's culture by encouraging team working. The staff member felt the actions taken had resulted in improvements which had benefited people over the last 12 months because staff now worked well together. Staff told us the registered manager's leadership style made them feel supported. One staff member said, "If I had made mistake I would 'hold my hands' up because the manager would help me to sort it out. She is approachable."

However, some staff told us they did not always feel valued by the management team. One said, "The deputy manager, if she calls you up for an extra shift, she will thank you, but the others…. you get no thanks." Another said, "I know they (managers) try but sometimes hard work isn't valued enough." The registered manager told us they felt disappointed some staff felt undervalued. They said they would discuss this at the next staff meeting to try and make improvements. Despite this, overall staff felt morale was mostly positive. Comments included, "We all seem to get along." "It is a really good team work here." And, "It is one of the best homes I've worked in."

The majority of staff told us their work performance was monitored through supervision meetings (one to one meetings with a manager). One said, "They (management) ask if I have any concerns or need any help with anything." Staff confirmed they had the opportunity to attend and contribute monthly team meetings to drive forward improvements. One commented, "Yes, we have meetings to discuss what is going on in the home and learn from previous mistakes." Minutes of a recent meeting showed fifteen staff had attended and they had been reminded of the importance of correctly completing paperwork. The outcome of a recent coroner's inquest and the lessons learnt by the home had also been shared and discussed.

The registered manager told us they had a 'hands on' approach, operated an 'open door' policy, and we saw they spent time sitting and talking with people during our visit. Overall, staff felt this was a good thing. One commented, "They [registered manager] can see how busy we are, credit where it's due she does come and help us out." Records showed the management team completed 'daily walk arounds'. This approach ensured managers had an overview of how staff were providing care to people. However, we could not be sure that areas requiring improvement such as, the mealtime experience or staff not always being responsive to people's needs had been identified.

We saw good examples of team work and communication between the staff and the registered manager

during our visit. We saw staff confidently approached the registered manager who provided them with support and advice. We looked at communication processes which included handover records. This showed us that staff passed on information and received important messages.

The registered manager said they were, "Pleased with the staff team and had worked hard to support staff to improve their practices," and it was, "Important to recognise the contribution individual team members made." The provider had a process of recognising individual staff member's commitment with 'Kindness in Care' awards. Staff who received the award were presented with a certificate and gift vouchers. Their photograph was displayed on the noticeboard in the entrance hall. Family members and staff confirmed they had the opportunity to nominate people who they felt should receive an award.

People and their family members were actively encouraged to put forward their suggestions and views about the service they received and the running of the home. However, they did not always feel confident actions would always be taken in response to their feedback . We looked at minutes from a recent meeting and we found they did not clearly reflect in detail what had been discussed or what actions had been agreed.

Annual quality questionnaire were sent out to gather people's views on the service they received. Completed questionnaires were analysed to assess if action was required to make improvements. At the time of our visit feedback from the 2017 questionnaires was still being analysed by the provider. We looked at the feedback which and been gathered in 2016. We saw 15 people had responded and 86 per cent of them had felt that the home was well led . An action plan had been implemented and this meant action had been taken to address areas that required improvement to benefit people who lived at the home.

We saw there was a 'Have Your Say' tablet computer in the entrance hall where people could give instant feedback about the quality of care within the home and share any concerns they had. The registered manager was instantly alerted via an email when any feedback was received. However, records showed in the last six months only one person had provided their feedback in this way.

There was a clear management structure in place at the home. The registered manager had been in post for over two years and had many years of experience of working in health and social care. They were supported by a deputy manager. Support was provided to the managers by the provider's assistant operations director. The registered manager told us, "I feel supported, (assistant operation director) is on hand if I need advice or support."

There were systems to monitor and review the quality of the service. The management team completed regular checks of different aspects of the service and shared the information with the provider. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. However, we could not be sure all of the checks such as, medication handling and care plan audits were always effective. For example, some plans contained conflicting information and others did not clearly reflect when a person's needs had changed.

The provider's assistant operations director completed monthly quality monitoring visits to the home. The last visit had been completed in May 2017 and records showed some areas had required improvement. For example, the report stated, '46% of Residents are prescribed an antipsychotic medicines. Home Manager needs to ensure that all of these medications are correctly prescribed and reviewed.' We were informed this action had been taken at the time of our visit.

A full internal audit of the home took place twice a year. As part of these visits records showed senior

managers spoke with staff and visitors and identified good practice and areas that required further development. These checks should ensure the home was run effectively and in line with the provider's procedures . An action plan was in place and being monitored to address the areas that had been identified as requiring improvement.

The home was also audited by external organisations. In February 2017 the local authority quality monitoring team had visited and they had made some recommendations to improve the service people received. The registered manager assured us the recommendations had been actioned at the time of our visit.

The registered manager told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly so we were able to monitor the information about the home.

It is a legal requirement for the provider to display their ratings so that people are able to see these; we found this had been done at the home and on the provider's website.