Crimson Care Limited

Crimson Manor

Inspection report

185 Scar Lane
Milnsbridge
Huddersfield
West Yorkshire
HD3 4PZ

Tel: 01484659176

Date of inspection visit:
28 September 2016
03 October 2016

Date of publication:
22 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Crimson Manor took place on 28 September and 3 October 2016 and was unannounced. The location had been most recently inspected during July 2015 and was judged as requiring improvement at that time.

Crimson Manor is a residential home, registered to provide care for up to a maximum of 20 people. Accommodation is provided in single en-suite rooms, over three floors, accessible by a passenger lift. There were 15 people living at the home at the time of this inspection.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Crimson Manor. The registered manager and staff were aware of relevant procedures to help keep people safe and staff were aware of signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and there were sufficient numbers of staff deployed to meet people's needs.

Risks to people had been assessed, however, some of these were generic in nature and some did not detail risk reduction measures which were in place for individuals.

Staff had received training in order to administer medicines safely. However, although staff had been trained, they did not always follow correct procedures when administering medicines.

Staff told us they felt supported and we saw staff received regular training and supervision.

Where people lacked capacity and were being deprived of their liberty, the registered manager had made appropriate applications to the supervisory body in order for this to be authorised. The registered manager acted in accordance with the Mental Capacity Act 2005.

People were given choices throughout the day and we saw staff sought consent from people prior to providing care and support.

People received appropriate support in order to have their nutritional and hydration needs met. A variety of healthy snacks and drinks were offered throughout the day.

People's rooms were clean and personalised. Pictorial signage was used throughout the home, to assist people to navigate around the home.

People told us, and we observed, staff were caring. People's privacy and dignity were respected.

Care plans were person centred and contained information to enable staff to provide care and support to people. Appropriate information was shared between staff to enable continuity of care.

Complaints were well managed and people we spoke with told us they would feel able to make a complaint if the need arose.

The registered manager was visible throughout the home and knew people's needs. We were told by staff, family members and a visiting professional that the home was well led.

The registered manager undertook regular audits in order to improve provision of service, although action resulting from these was not always recorded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always administered and recorded appropriately.

Accidents and incidents were monitored, actioned and analysed.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Sufficient numbers of staff were deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had received training, support and supervision to enable them to provide effective care and support to people.

The principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were upheld.

People received support to access health care services.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring.

We observed reassuring, positive and caring interactions between staff and people.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's preferences, choices and personal histories.

We observed people making their own choices.

Complaints were well managed and encouraged as an opportunity for learning.

Is the service well-led?

Good

The service was well led.

Relatives and staff told us they felt the registered manager was approachable.

We observed the registered manager knew people and their needs.

The registered manager was aware of, and adopted principles of, evidence based, best practice.

Ongoing improvements were evident since the previous inspections.

Crimson Manor

Detailed findings

Background to this inspection

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

The inspection of Crimson Manor took place on 28 September and 3 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors on the first day and one adult social care inspector on the second day of the inspection.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority, the clinical commissioning group and Healthwatch, as well as information we received through statutory notifications. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us to understand the experiences of people who lived at the home, including speaking with people, making observations and inspecting records. We spoke with three people who lived at the home, three relatives of people who lived at the home, four care staff, the head chef, the care manager and the registered manager. We also spoke with a visiting professional.

We looked at seven people's care records, three staff files, staff training records, as well as records relating to the management of the service and the maintenance of the home. We looked around the building and saw people's bedrooms, bathrooms, communal areas and outside space.

Requires Improvement

Is the service safe?

Our findings

We asked a person whether they felt safe living at Crimson Manor. They told us, "Course I'm safe." Another person agreed and said, "Yes, we are."

A relative we spoke with told us they felt the home was a safe place for their family member to live.

The registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. A member of staff said, if they suspected any abuse, "I'd go straight to the manager. If it was a manager, I'd go to safeguarding." Another member of staff told us, "If I had any concerns about bullying or service users I'd inform the manager. We also have a whistleblowing policy." This showed staff would take appropriate action if they had concerns anyone was at risk of abuse or harm.

Records showed two-hourly checks were made on individuals throughout the night, where people had consented to this or where a decision was made in their best interests in order to help keep them safe. Due to a recent allegation relating to neglect and acts of omission, a referral had been made to the local safeguarding authority. The allegation was found to be unsubstantiated, however, some learning had evolved from this regarding the recording of checks. We saw training had taken place in relation to appropriate recording and this included the importance of record keeping and use of professional language. All of the records we sampled showed the checks had taken place.

The registered manager told us risks were assessed by the care manager and deputy care manager. Risks associated with mobility, falls and skin integrity for example had been assessed using risk assessment scoring tools and these were reviewed monthly. Although further information regarding how to reduce risk was then included in care plans, such as the needs assessment, we found these did not always contain sufficient personalised information. Further information would improve the quality and usefulness of the risk assessments. We shared this with the registered manager who agreed to consider this further.

The home was split over three floors with the communal lounge and dining areas located on the ground floor. There was a lift available for people to use. We used the lift and noted that, although the lounge and communal areas were labelled in the lift to assist with navigation, there was lack of signage or instruction to guide people as to what to do if the lift broke down. There was a label with a telephone number to call but, unless the person had a telephone on them, this would not be useful. We shared this with the registered manager and care manager who agreed to address this. We found this had been addressed by the second day of the inspection and notices were displayed in the lift, highlighting which button to press in an emergency. The registered manager highlighted that, at the time of the inspection, no-one living at the home would use the lift independently. The registered manager advised us that, if staff had any concerns regarding a person's ability to use the lift or cope in the event of a lift breakdown, a risk assessment with appropriate mitigating action would be carried out at that time.

Regular safety checks took place throughout the home in relation to, for example, nurse call bells, window restrictors and equipment such as wheelchairs and fire safety apparatus. Records showed fire alarms,

emergency lights and fire doors were checked regularly. Tests such as gas safety and portable appliances had been completed. We saw a maintenance log book in which staff recorded any maintenance concerns that required attention, and these were actioned. This helped to ensure the safety of premises and equipment.

We asked staff what action they would take in an emergency and staff were confident they would contact 111 or 999 for assistance. We saw action had been taken by the registered manager on an occasion where a member of staff had failed to take appropriate action, following a person's fall. Subsequently, all staff had been reminded of emergency procedures or actions to take following falls or serious injuries. Staff demonstrated to us they knew what action to taken in an emergency or in the event of a death at the home. Personal emergency evacuation plans were in place and staff had access to these. These helped to ensure people could be evacuated safely in the case of an emergency.

Accidents and incidents were logged and recorded appropriately and this included any investigation, outcome and actions. A monthly analysis took place and this helped to ensure the prevention of future accidents or incidents. We saw actions had been taken following accidents such as areas being assessed for hazards, GPs and emergency services being contacted and referrals being made to other specialist teams for further assessment.

On the first day of our inspection, we arrived early in the morning in order to speak with staff who were completing their night shift. Staff told us there were two staff working during the night and one of these staff undertook checks on people whilst the other member of staff completed tasks associated with laundry and cleaning. All the staff we asked told us the care and wellbeing of people living at the home was more important than the domestic tasks and that staff worked together to ensure appropriate checks were made on people. One staff member said, "It works quite well actually. If a buzzer goes and the other carer is busy, I stop the laundry and do it [attend to the person who pressed their buzzer.]"

The registered manager told us they used a dependency assessment tool in order to assist in determining the numbers of staff required to meet people's needs and we saw evidence of this. This tool took into account needs relating to, for example, moving and handing requirements, behavioural support and diet and nutritional needs. This was used to help determine staffing numbers and levels required. Agency staff were not deployed at the home and this helped to ensure continuity of staff.

The registered manager told us, and records showed, three carers worked through the day and two worked through the night. A head chef was employed as well as a cleaner each day. The structure of shifts and working patterns had recently been reviewed and there was an overlap of shifts between 7am and 8am with a view to making the morning period more effective in terms of staffing. The registered manager told us a manager was present 8am to 4.30pm seven days a week and there was an on call system. This showed the registered manager reviewed staffing levels.

A care worker confirmed there had been some changes to shift patterns and said, "We've tried for three or four weeks a change of hours. Three care workers during the day. I think it's better as there are more people [staff] to help service users up in time for meals and activities. You're not rushing around as much." This staff member told us, "We don't wake people up. There are people who want to get up at that time."

A family member told us, "Yes, there are enough staff, and they're very obliging." When we asked another family member whether they felt there were enough staff, they said, "Yes, I think so. If the buzzer goes, they're straight here. They meet people's needs."

A carer we spoke with told us they felt there were sufficient numbers of staff to meet people's needs but said, "During the day carers do activities and it makes it difficult if there's then only two carers on." Another member of staff we asked said, "Yeah, I think so," when we asked whether they felt there were enough staff.

A visiting professional we spoke with told us, "I never have to stand around, waiting for a member of staff. There seems to be enough staff, yes. Much better than some other homes."

We sampled three staff files and found safe recruitment practices had been followed to help ensure staff were safe to work with vulnerable people. For example, the registered manager ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups of people.

We saw the registered manager took action to address staff when their conduct fell below that which was required. For example, a staff member had failed to take the correct action following a person who had a fall. The registered manager addressed this with the staff member and we saw when the same staff member was on duty on a subsequent date, they took the correct action following another fall. This showed mistakes were addressed and learning took place to improve staff performance.
We looked at whether medicines were administered and managed safely. Medicines were administered in a calm, patient and kindly manner by a carer who was wearing a tabard to indicate they should not be disturbed. This reduced the risk of errors being made.

Records showed the times that medicines were administered was recorded and this helped to ensure people were given medicines at appropriate and safe intervals. One person had refused to take their medicine and the carer recorded this appropriately on the medication administration record (MAR).

We checked some random samples of MARs to determine whether they reconciled with the medicines. For each record we checked, the stock of medicine remaining was correct according to the MAR. Stocks of medicines were regularly audited and we saw records of this.

The clinic room where medicines were kept was clean, tidy and well organised. Doors and medicine trollies were kept locked and this prevented unauthorised access. Displayed in the clinic room was information relating to the Mental Capacity Act 2005, treating people with dignity and, 'The six rights of administering medicines.' This helped to prompt staff to follow appropriate guidelines and best practice.

Some people were prescribed PRN (as required) medicine. PRN protocols were in place and we observed the staff member ask people whether they required their medicines, in line with the protocol. However, one person was given their PRN medicine, without being asked whether they were in pain or whether they required their medicine. We asked the staff member why they had not followed the protocol in this instance and they told us the person had been in pain and the doctor had recently visited and advised the medicine should now be given at each administration. However, this had not been recorded on the MAR to reflect this. This meant the person was at risk of medicine being administered incorrectly. We shared our findings with the registered manager who, on the second day of the inspection, confirmed the staff member had received refresher training.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely as required and the drugs that were required to be logged in the register were recorded as such. This showed controlled drugs were managed appropriately.

Some people were prescribed topical creams. The registered manager had an effective system in place to ensure opened creams were discarded of in a timely manner. This helped to prevent and control the spread of infection.

We observed the member of staff administering medicines wore the same pair of gloves whilst administering medicines to different people, including the application of eye drops. This increased the risk of the spread of infection and we highlighted this to the registered manager. This was immediately addressed and the staff member received refresher training.

A recent infection prevention and control audit had been undertaken at the home and the registered manager had been issued with a certificate of recognition for achieving 96%. We noted the home was clean and there were hand sanitisers placed around home. Bathrooms were stocked with soap and paper towels. Staff were observed to be wearing personal protective equipment.

The previous inspection had found concerns regarding a dog that regularly visited the home. We found risk assessments were in place regarding the presence of a dog, including measures to reduce associated risks such as the dog not entering dining areas when people were eating. A member of staff said, "It's fine. It's lovely. Very placid and calm." A relative told us, "I may have seen the dog, yes. It's not a problem." People had been asked for their views regarding the dog through the care planning process. All of the plans we sampled indicated the person liked the dog.

Good

Is the service effective?

Our findings

We asked a family member whether they felt staff were well trained and we were told, "Yes, I would say so." One relative told us, "[Name]'s general health has improved since being here. Their communication and agility have improved." Another relative told us, "It's an excellent place. It's the best I've seen."

A staff member told us, "I'm confident I know people and their needs."

We spoke with a visiting professional and asked whether they felt staff were effective and appropriately trained and they confirmed this to be the case. They said, "Staff are on the ball."

A care worker we spoke with, who had recently started employment at the home, told us they had read safety booklets and policies and they were introduced to all of the people who lived at the home. The care worker had spent three days shadowing other members of staff. This care worker told us they had received training regarding how to safely move and handle people and there was a practical element to this training where they used equipment to move a colleague. In all of the staff files we sampled we saw staff had been issued with the code of conduct for health and social care workers. Records showed staff had received training in areas such as fire safety, safeguarding, dignity in care, dementia care, health and safety, moving and handing, the Mental Capacity Act 2005 and the administration of medicines where appropriate. This showed staff who were providing care and support to people had received information and training to do so effectively.

We were told, and records showed, new staff were working towards the framework of the Care Certificate, although the registered manager had not yet put into place a system of certifying competence in relation to observations of practice. However, the registered manager and care manager had received training in this area and this was ongoing. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

One member of staff said, "We've been having loads of training. We went for a full days moving and handing training [off site]. It included practical." Another staff member said, "I feel competent. The training is sufficient. I've asked for additional support when I felt it was needed and that wasn't a problem."

A further staff member said, "I've done all my mandatory training and train the trainer for moving and handling and first aid. The management call us in every six months to do training. They're quite hot on their training updates. I did the care certificate this year."

We saw staff received regular supervision and we sampled some minutes from supervision meetings. Items discussed included health, accidents, training, issues and problems, concerns from the member of staff, positive feedback from management and areas for development. This showed staff were receiving ongoing supervision in order to develop.

Many staff were designated 'Champions' in different roles such as dignity, medication, nutrition, foot care and activities for example. Staff had received training and part of their role was to monitor and improve their area of expertise across the home.

The registered manager was familiar with sources of best practice information, such as the National Institute for Health and Care Excellence (NICE) guidelines, Food Standards guidelines, Health and Safety Executive (HSE) guidelines for care homes and infection control guidelines. The registered manager had completed a recognised programme for managing health and safety. The registered manager was familiar with Dementia Care Mapping and had received training in this approach. Dementia Care Mapping is an established approach to achieving and embedding person-centred care for people with dementia, recognised by NICE. The aim of this approach is to take the perspective of the person with dementia in assessing the quality of the care provided. This showed the registered manager was seeking and implementing recognised best practice.

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.

We saw evidence that mental capacity assessments had been completed. One person's care plan stated, '[Name] is able to make decisions and express preferences from options such as what to eat/drink but lacks capacity to make more complex decisions.' We saw evidence the person's capacity had been assessed and decisions had been made in their best interests where appropriate.

Care plans contained information relating to people's capacity to consent to living at the home and to receiving care and treatment. We saw either consent had been given or, where people lacked capacity to consent, appropriate assessments had been completed and best interests decisions made, in consultation with the person, their family and other relevant people.

People were consulted regarding whether they wished to have their rooms open or locked throughout the day and whether they wished to have a key and their decision was recorded. For people who lacked capacity, an assessment had been undertaken and a decision made in their best interests.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had submitted appropriate applications to the supervisory body and appropriate records were kept which enabled the application process to be effectively managed. The registered manager demonstrated awareness of the need to maintain people's safety but without overly impacting upon their quality of life and right to liberty.

We checked whether specific conditions, as specified as part of the authorisation, were being met. One person had a DoLS authorisation in place but it had been determined in their best interests they should only be checked once through the night, at 1am, as opposed to every two hours, in order that their liberty was deprived in the least restrictive way. Records showed this was being adopted. This showed the registered

manager was acting in accordance with the MCA and DoLS.

People received appropriate support in order to have their nutritional and hydration needs met. We saw hot and cold drinks, snacks and smoothies were regularly offered to people. During June 2016, the home had been awarded the 'Gold Healthy Choice Award' for being committed to 'Good standards of food hygiene and healthy food options'. We saw fresh fruit and vegetables and all foods were made fresh at the home by the head chef. An inspector sampled a lunchtime meal with people and found this to be good quality. Two people commented they liked the food. The home had been awarded five stars, which equates to, 'Very good' at their most recent food hygiene inspection, of May 2016.

The head chef was knowledgeable about people's likes and dislikes and had access to information relating to people's dietary needs, such as diabetes. There were copies of people's nutritional care plans in the kitchen. The head chef identified any potential allergens in meals. People's food and fluid intake was recorded.

We saw a notice displayed in the reception area which stated, 'We welcome friends and relatives to join residents for occasional meals. This is free of charge.' Further, care workers also sat and ate their meals with people who lived at the home. Appropriate support was offered to people and this created a homely and relaxed atmosphere at meal times. A family member told us, "If you ring up the night before, you can come in and take a meal."

We looked at the layout and design of the premises. The lounge was split into two areas; one being quieter. We saw in the quiet area there was large bookcase, with ample books and games and items of interest. There was a large fish tank in the lounge area with an abundance of fish. This looked visibly clean and well maintained. The registered manager was aware of recent evidence based research which identified that watching marine life and fish tanks could have the effect of lowering heart rate and improving psychological wellbeing.

The reception area displayed pictures of staff on duty and identified their roles. This helped people to know which staff were responsible for different areas and they were more easily identifiable.

People's bedrooms doors had photographs and names displayed on the door. This helped people to navigate and find their own rooms more easily. We noted some signage that was appropriate for people living with dementia such as signs for the lounge and toilets. There were photographs of people who lived at the home on the walls and there was a homely feel. The home looked and smelled clean and fresh. There had been some improvements to the environment since the last inspection such as refurbishment of the kitchen, some bedrooms, corridors and stairways and medication room for example. New furniture had been provided and the lounge area had also been refurbished. Plans were being considered in order to extend the dining area but work had not yet begun in this area.

There was a communal bathroom on the ground floor which we saw people using throughout the day. However, there was also another door in the bathroom leading to a person's bedroom and the inspector found this door was not locked. This meant a person in the bathroom could enter the person's bedroom or the person in the bedroom could enter the bathroom whilst it was in use by someone else. Although the person whose bedroom this was had been consulted and consented, we highlighted this to the registered manager as we were concerned for the potential of people's privacy and dignity being compromised. The registered manager agreed to further consider this. On the second day of the inspection, we found the registered manager had displayed notices and had a new lock fitted which meant the person using the bathroom could lock the door.

We found evidence of referrals to other healthcare professionals such as GP, district nurses, speech and language therapists and physiotherapists. This showed people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

We asked people whether staff were caring. One person told us, "I love it. They're lovely [referring to staff.]" Another person, who did not communicate verbally with us, smiled and nodded when we asked if staff were kind.

We spoke with a visiting professional and asked them whether they felt staff were kind. We were told staff were very caring and helpful.

A family member said, "I'd give them 11 out of 10 for caring. The cook is also excellent."

Another family member said, "Could not fault the staff. They're lovely." They added, "They don't know when we're coming but [name]'s always clean."

A care plan we inspected stated, 'Staff are to support [name]'s decision making process and allow [name]'s independence of choice where possible.' This showed, as part of the care planning process, consideration was given to promoting independence. We saw examples of this in practice. Many of the people living at the home required a level of assistance to stand and move, but not to the extent they required moving equipment to be used. We observed staff to be very patient and encouraging. People were receiving the level of support required but without staff taking away their independence. Staff were encouraging towards people.

We observed a member of care staff painting with people during the afternoon of the first day of our inspection. We found the staff member to be patient and encouraging with people. The staff member offered assistance but encouraged people to be independent. The interactions were warm and caring and we could hear the staff member engaging in conversation and showing interest in people.

We saw staff offering discreet assistance when this was required and staff knocked on bedroom and bathroom doors before entering. This helped to ensure people's dignity was maintained. Some staff were designated dignity champions and they undertook dignity audits. Learning was shared with staff in relation to good practice and areas for improvement, in terms of upholding people's dignity. This demonstrated the values of privacy and dignity were promoted.

We overheard a carer say to a person who was in their room, "What do you fancy for breakfast?" The person made very specific requirements regarding their choices and this was accommodated. The carer immediately communicated to the head chef what the person would like and this was prepared. This showed people felt able to make specific requests and staff respected this.

Many times throughout the inspection, we overheard carers talking with people. Carers appeared to show a genuine interest in people's lives and their wellbeing and they knew people well. People appeared relaxed and happy in the presence of carers, chatting and laughing and joking. We observed appropriate body language and touch being used throughout the inspection.

Carers were respectful of people's wishes. We observed a carer ask a person if they wanted assistance to move to the dining area at lunchtime. The person preferred to stay where they were seated and staff were respectful of this, bringing the person a small table from which to eat their lunch.

On other occasions we heard and saw care staff asking people if they wanted to join in with activities. Some people were keen and others refused. Again staff were respectful of this, but ensured that everyone in the room was asked whether they wanted to participate.

The registered manager told us they were working towards the Gold Standard Framework, which is a model of good practice that enables a 'gold standard' of care for people who are nearing the end of their lives. Although not yet accredited with the scheme, this was ongoing and the structure of care plans was being reviewed to include improved recording of people's wishes at the end of their life.

Records were kept of people who had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order in place. There was also a list of residents and whether a DNACPR was in place in the hospital folder. This meant staff had access to this information and it could be shared with emergency services as appropriate. This meant people's decisions could be respected in terms of whether they should be resuscitated.

One person who lived at the home had been identified as having no family involved in their care planning and decision making. This person had an advocate appointed. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

Good

Is the service responsive?

Our findings

A person told us, "I enjoy reading the local paper. They've brought that for me, see [showing us the newspaper]. I used to read it at home."

A family member told us, "They do exercises and [name] loves that. All the ladies have had their nails done." We also observed, during our inspection, many ladies at the home had their nails painted.

A care record had been developed for each person living at the home. We sampled four people's care records. These were person centred and included important information to enable staff to provide care and support to people. At the front of each care plan we viewed we saw a photograph of the person and crucial information such as whether a DNACPR was in place. We asked a care worker whether they were able to read and access people's care records and they confirmed this was the case.

Information in care plans included the support each person required in relation to their needs such as around daily routine, medical, sensory, mobility, nutrition, oral care, continence, behaviour and night care needs.

A new key worker system had been recently introduced, whereby specific staff would be responsible for ensuring care plans were reviewed with people. We asked a member of staff specifically about one of the people for whom they were the allocated key worker and the staff member was able to give a detailed account of the person's likes, dislikes, background and needs. A family member we spoke with told us they were involved in the care planning for their relative.

Care plans contained a psychological and social section. In the plans we sampled we found this information to be detailed and included information such as the person's preferred activities, family history, what the person wanted to be called and their likes and dislikes. This section of the care plan also asked for the person's views on a dog visiting the home. This information is useful to enable staff to build positive relationships with people and for people to receive personalised care and support.

Care plans were detailed and included, for example, specific phrases that staff could use in order to reduce a person's anxiety. One person became anxious if they became disorientated and their care plan informed staff to use phrases to help orientate the person to time and place such as, 'It's 12.30 in the afternoon now [name], would you like to go to the dining table?' This enabled staff to provide support appropriate to that person's specific needs.

We saw staff completed daily notes regarding the support people had been offered and received. We saw nightly checks had been recorded and staff also completed daily notes which were written in a personalised and respectful way. Notes included information relating to the support provided, the person's mood, food and drink and participation in activities. Where support or activities were declined, we saw this was recorded in the records we sampled.

We considered the range of activities and occupation for people living at the home. Activities were planned and we observed activities taking place. People joined in and appeared to enjoy them. The management team delivered some cognitive stimulation therapy which is a non-pharmacological intervention for cognitive symptoms and maintaining function for people with mild to moderate dementia. This approach is recognised by the National Institute for Health and Care Excellence (NICE).

Activities included chair exercises, trivia, circle dance, life stories, baking, time in the garden and participation in community events. A group had recently attended a local food and drink festival and tea dance in the local community. Evaluation sheets were completed for activities that had taken place. These recorded whether people were interested and appeared to enjoy the activity, people's mood and who joined in. This helped to identify which activities were popular and helped the registered manager and staff determine and plan activities more effectively.

On the first day of our inspection we observed a care worker facilitating some morning activities and exercises with people. In the afternoon some people played dominoes with a care worker and some painting and life story work took place. On the second day of our inspection an entertainer was playing the guitar and singing in the lounge. It was evident people very much enjoyed this, as they were singing along and clapping and smiling. We saw a member of care staff sat with people and joined in and this helped to create a homely, friendly atmosphere.

Regular visits took place at the home from different religious leaders and groups. We saw in the care plans we sampled, people's views and wishes had been taken into account in relation to this.

Throughout the day we heard care staff offering people choices, such as asking people where they wanted to sit, or what people wanted to eat and drink. We observed staff seeking consent prior to assisting and supporting people. When people refused offers of assistance and made their own choices, this was respected. This showed people were given choice and helped to ensure people retained control.

People's rooms were clean and tidy. We saw people had access to their own toiletries. Photos and items of sentimental value were on display in people's bedrooms which helped to create a homely, personalised environment. This showed people were able to personalise their environment.

We looked at the complaints file and found that few complaints had been received but, when they had, they had been investigated, action taken and the complainant responded to with an apology offered. A relative we spoke with told us they had not had cause to complain but would feel able to do so if they needed to. The registered manager recognised the formal complaint system may be deterring people from making complaints. Therefore a minor complaints log had been devised, in order to record and learn from minor concerns that could be raised informally. This showed complaints were managed effectively and learning took place as a result.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since September 2013.

We asked a family member whether they felt the home was well led. Their response was, "Well led? Yes, I would say so." Another family member told us, of the care manager, "[Name] is very calm and has an obliging attitude."

A staff member said, "I love working here. I love my job." Another member of staff said, "The two managers are massively helpful." A further staff member told us, "[Name of managers] are brilliant."

One member of staff said, of the registered manager, "I admire [name of registered manager] for all the activities and different foods. It's all aimed at the residents."

A visiting professional also told us they felt the home was well led and said, "This is one of the homes I'd be happy to end up in myself."

A staff member told us, and records showed, staff meetings took place once a month. A member of staff told us incidents were discussed during meetings, as well as ideas for improving the home. Another member of staff told us care workers were involved in the meetings. We looked at the minutes from a staff meeting and found items discussed included a reminder of the importance of accurate recording, moving and handling procedures, review of shift times, staff reminded to seek medical help following falls and champion roles were explained. A staff suggestion box had been added to encourage feedback from staff.

Regular management meetings were also held. We looked at minutes from a management meeting and found items discussed included a review of accidents, dependency levels and discussions regarding staffing. Shift patterns were reviewed and we saw the minutes stated, in relation to the change of shift patterns, 'Better system – residents able to get up when they wake instead of waiting.' This showed the registered manager was holding regular meetings. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Good teamwork was evident from the way staff worked together. Staff were recognised for working well as a team. A 'Team worker of the month' was nominated each month by other staff members and they received recognition. This encouraged team work and awards such as this can help to motivate staff.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

Questionnaires were sent to residents and relatives in order to obtain their views and feedback. We saw the

results from some questionnaires that had been sent to people during 2016. These showed, in terms of overall satisfaction, 50% of relatives found the home to be 'Very Good,' 25% found the home to be, 'Excellent' and the remaining 25%, 'Quite Good.'

10 questionnaires had been completed by people who lived at the home and all said they were happy and content within the home. All felt the numbers of staff were either, 'Good,' or 'Excellent'

It was clear the registered manager had made improvements to the home since the previous inspections. Regular audits took place, for example in relation to infection control, nutrition, medication, and mattresses. We saw some actions had resulted from audits, such as a medication audit which led to a staff member being addressed in relation to poor recording. However, we found other audits lacked evidence of action being taken and some areas for concern had not been identified such as issues associated with shared access to bathrooms. We discussed this with the registered manager and care manager who advised they were aware of this and were looking to improve recording. On the second day of the inspection we were shown a new system that had been introduced to improve the recording of actions from audits.

The registered manager was currently studying for a Masters Degree in Dementia Studies. They were knowledgeable and aware of current research and good practice in relation to dementia care and were keen to obtain accreditation and recognition of good, evidence based, practice. The registered manager told us they were involved with a particular end of life programme, Namaste Care. This is a program designed to improve the quality of life for people with advanced dementia. We saw a room was being developed in order to provide appropriate space for people to enjoy quiet time. The registered manager told us their vision was to continue researching ways of best practice, in order to provide better quality of care for people. This included adopting the principles of Namaste Care and the Gold Standards Framework in relation to end of life care.

Links with local community groups and faith groups were evident. We saw volunteer groups, faith leaders and activity entertainers visited the home regularly. Furthermore, people living at the home attended local community events. This showed the registered manager engaged with the local community and this also helped to reduce the risk of social isolation of people living at the home.

Throughout the inspection process the registered manager and staff engaged with the inspection team and were receptive to the findings of the inspection. Concerns found or suggestions made were acted upon and the registered manager appeared keen to continue driving improvements at the home.