Bamford Care Homes Limited

Quinnell House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 14 and 17 May 2018 and was unannounced. At the previous inspection of this service in February 2017 the overall rating was requires improvement. At that inspection we found Breaches of Regulation 9, 11 and 17. This was because the provider had not ensured that people received person centred care and the risk of social isolation had not consistently been mitigated. The registered provider had failed to maintain accurate, complete and contemporaneous records and the principles of the Mental Capacity Act (MCA) 2005 had not been consistently applied in practice.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, responsive and well led to at least good. This inspection found improvements had been made and the breaches of regulation met but improvements were needed in well-led to ensure that quality assurance systems were further improved and embedded in to every day practices.

Quinnell House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Quinnell House was registered to provide support to a maximum of 56 people who lived with dementia. The service does not provide nursing care on site and used district nurses to provide support when needed. 38 people were living at Quinnell House at the time of our inspection.

The service had a registered manager. 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.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan as stated in their provider information return (PIR), and confirm that the service now met legal requirements. We found improvements had been made in the required areas. The overall rating for Quinnell House has been changed to good. We will review the overall rating of good at the next comprehensive inspection, where we will look at all aspects of the service to ensure the improvements have been sustained.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement. However, we found that audits were not consistently effective as they had not identified shortfalls in the management of diabetes and not all records to support the care delivered were consistently completed.

People told us they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new

staff were safe to work within the care sector. Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of Equality, diversity and human rights. Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with specific health disorders, such as diabetes. Formal personal development plans, including two monthly supervisions and annual appraisals were in place. Staff were supported to become 'champions' in areas of care delivery such as medicines and moving and handling. People were supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. The dining experience was pleasant and inductive to encouraging people to eat. People chose where to sit and it was a pleasant and social experience. One person said "The food here is excellent as good as a restaurant, fresh fruit, cakes and we can have anything at any time if we are hungry." Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. People told us, "Staff are kind and lovely, nothing is too much trouble," and "Very happy here, very caring." Visitors told us, "Impressed with their kindness and knowledge," and "I trust them and they have never let me down." Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People chose how to spend their day and staff were seen to support and guide people with kindness and empathy.

People were supported in a personalised way that reflected their individual needs. A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the day, seven days a week and were developed in line with people's preferences and interests. Further ideas for the prevention of social isolation for people who remained in their rooms were being discussed by the management team. Technology was used to keep families up to date if they lived away this was via protected internet access so they could discuss their loved ones' care. There was a complaints policy and form available to people. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. People received a pain free and dignified death at the end of their lives. Staff supported people with compassion and worked with local hospice teams as required.

People and staff were positive about the culture of the service, staff and relatives felt the staff team were approachable and polite. The staff team worked in partnership with other organisations at a local and national level to make sure they were following current good practice. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service. Relatives told us they could visit at any time and they

were always made to feel welcome and involved in the care provided.

Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

The provider had sent CQC notifications in a timely manner. Notifications are changes, events or incidents that the service must inform us about.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Quinnell House was safe and had met the legal breach previously found.

Risk to people had been assessed. There was clear guidance for staff to follow to reduce the risk, ensure people were independent and made safe choices. Accident and incident were recorded and action was taken to reduce the risk of a re-occurrence.

Staff had attended safeguarding training and had a clear understanding of abuse, how to protect people and who to report to if they had any concerns.

Medicines were managed safely. Staff had attended relevant training, there were systems in place to ensure medicines were given as prescribed and records were accurate.

Is the service effective?

Good

Quinnell House was effective and had met the legal breach previously found.

People were supported to access healthcare support. People's individual needs were met by the adaptations made at the home? and the design of the service.

Staff had the relevant skills and knowledge to deliver care and support to people they supported. Training was provided regularly. Consent to care and treatment was sought in line with legislation

People were supported to eat and drink enough to maintain a balanced diet.

Is the service caring?

Good

Quinnell House was caring.

Staff provided the support people wanted, by respecting their

choices and enabling people to make decisions about their care.

People's dignity was protected and staff offered assistance discretely when it was needed.

People were enabled and supported to access the community and maintain relationships with families and friends.

Is the service responsive?

Good

Quinnell House was responsive and had met the legal breach previously found.

Care plans had guidance for staff to follow if a persons health needs change or if they were in need of end of life care.
People received personalised care and were included in decisions about their care and support.
A complaints policy and procedure was in place and available to people.Feedback from people was sought and their views were listened to and acted upon.

Is the service well-led?

Requires Improvement

Quinnell House was not consistently well-led, whilst meeting the breach of regulation previously in breach, there were still some improvements required to improve outcomes for people and embed good practice in to everyday care delivery.

There were systems for assessing, monitoring and developing the quality of the service being provided to people. However, these need to be developed further to ensure they identified the inconsistencies found in peoples records,

The views of people and others were actively sought and acted on. Staff felt empowered and supported to be involved in the running of the home and making suggestions for change.

The service continuously learned and improved and staff were given opportunity to progress. The service worked effectively in partnership with other agencies.

Quinnell House

Detailed findings

Background to this inspection

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

This inspection took place on the 14 and 17 May 2018 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports and any notifications they had sent us. Notifications are information about significant events that the provider is legally obliged to send to the Care Quality Commission. We also reviewed the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the providers action plan following the last inspection.

During the inspection process we contacted the local authority with responsibility for commissioning care from the service to seek their views. We also spoke with and received correspondence from three visiting health and social care professionals.

During the inspection we spoke with 15 people that used the service and 14 members of staff: the provider, registered manager, deputy manager, domestic and nine care staff. We reviewed four sets of records relating to people including care plans, medical appointments and risk assessments. We looked at the staff recruitment and supervision records of four staff and the training records for all staff. We looked at medicines records of people and minutes of various meetings. We checked some of the policies and procedures and examined the quality assurance systems at the service.

Good

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in February 2017. At that inspection we found a breach of the legal requirements. This was because the provider had not ensured that the documents to ensure peoples safety was consistently completed. We also made a recommendation in respect of the management of covert medicine.

At this inspection we found improvements had been made and that they now met the previous legal breach of regulation.

People who used the service and their relatives told us they felt safe. One person who used the service told us, "Yes, I am safe here, they look out for us." Another person said, "Very kind staff and I'm very safe."

This inspection found people's ability to use and access the call bell had been assessed and call bell risk assessments were seen in care files. Where people chose to stay in their rooms guidance for staff to follow was available and demonstrated that regular checks on their safety were undertaken.

People told us they received their medicines safely and on time. One person told us, "I have no worries about how they give me my pills." People's medicines were securely stored in a locked cupboard and they were administered by senior care staff who had received appropriate training and regular competency checks. The registered manager had undertaken a medicine training course that enabled them to train senior care staff within the service in the management of medicines. A senior care staff member was the medicine champion and took responsibility for checking the medicines in and monitoring the MAR charts. People were supported with their medicines by senior staff. We observed medicine being given to people and saw that staff ensured people received their medicines safely, on time and that staff signed that they had been given.

Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts indicated that medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered correctly. There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests. There was a covert medicines policy and procedure and where people received their medicines covertly (disguised in food or drink), documentation confirmed this had been approved by the prescribing GP. There was now underpinning evidence that a mental capacity assessment had been undertaken which determined whether the person could consent and was in the individuals best interest.

Risk assessments provided guidance about how to support people in a safe manner and mitigate any risks they faced, both health wise and socially. The registered manager told us, "Staff get training on identifying risk. We identify risks from people's life history, current problems and health conditions. It's about being

capturing people's risks individually." Risk assessments balanced safety with allowing people to make their choices and remain independent. Risk assessments were person specific and based around the individual risks people faced,for some people this was linked to behaviours that may challenge. Staff discussed management strategies and how to measure their effectiveness. A staff member said, "We observe people and get to recognise changed behaviours, such as increased restlessness. This gives us trends and themes so that we can monitor risk. When people are unwell, with a chest or urine infection, we know that this may increase confusion and so are extra vigilant." Staff said, "We don't want to stop them enjoying their life so we support them to keep safe and well, doctor's appointments, health monitoring and mental health support."

Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. Care plans looked at the person's identified risk and included a plan of action to promote safe care. People identified at risk from pressure damage had pressure relieving mattresses and advice was sought from district nurses. People who lived with diabetes had a care plan that contained a flow chart detailing the action to take in the event of hypoglycaemia (low blood sugar) and hyperglycaemia (high blood sugar). We found some shortfalls within these care plans and risk assessments in respect of the management of high blood sugars. (The district nurses administered insulin at Quinnell House. These were immediately acted on, on the first day of the inspection and advice sought from the GP who took immediate action with the district nurses. This meant the risk was immediately mitigated because responsibilities of healthcare professionals and care staff were now clearly defined.

Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Recruitment checks had been carried out to ensure that the staff who worked at the home were suitable to work with vulnerable people. These included references, identity checks and the completion of a disclosure and barring service (DBS) check. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and help prevent unsuitable people from working with vulnerable groups.

Staff had received training in safeguarding adults and records confirmed this. Staff understood their roles and responsibilities in supporting people to keep safe from potential harm or abuse. Staff were knowledgeable about the different forms of abuse and how to recognise the signs of abuse taking place. Staff told us, they would not hesitate to report abuse to the registered manager and were confident they would take appropriate action. The registered manager understood their responsibilities in reporting any concerns about people's safety which included reporting incidents of potential harm or abuse. The registered manager told us, "The local authority provides us with training and we also discuss safeguarding in team meetings and one to ones." A staff member said "I would report any issues or safeguarding concerns to the manager or local authority." They also told us told us, "There are various kinds of abuse; physical, financial, emotional, sexual. If I come on shift and I am alerted to something I'd check the person to make sure they're ok and then do an incident report and tell the manager. I'd also inform CQC." Policies and procedures were in place for whistleblowing and safeguarding, as well as policies in relation to emergencies, fire safety, medicines, bullying and harassment. Staff told us they felt protected to whistleblow. A whistleblower is a person who informs, in confidence, on a person or organisation seen to be engaging in an

unlawful or immoral activity. A care staff member said, "I've never had to do it but I feel we are protected and safe to do so."

People were safe from the risk of emergencies. Robust fire procedures included individual Personal Emergency Evacuation Plan (PEEP) in place. PEEPs identify people's individual independence levels and provide staff with guidance about how to support people to safely evacuate the premises. The provider recorded when fire drills were completed and all staff received fire training. A business contingency plan addressed possible emergencies such as extreme weather, infectious diseases, damage to the premises, loss of utilities and computerised data. Procedures identified ensure people had continuity of the service in the event of adverse incidents.

Risks associated with the safety of the environment were identified and managed appropriately. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances and legionella, maintenance and servicing of equipment such as fire alarm, portable appliance testing (PAT), lift, and boiler were seen to be routinely undertaken. The provider used the services of a maintenance worker who carried out routine checks and oversaw aspects of environmental safety such as checks on mobility aids.

People were cared for in a clean, hygienic environment. The service and its equipment were clean and well maintained. There was an infection control policy and other related policies to guide staff in the prevention of cross infection. People and visitors told us that they felt the service was clean and well maintained. One person said, " It's is very clean." Protective Personal Equipment (PPE) such as aprons and gloves were readily available. Staff used PPE appropriately during our inspection and it was available for staff to use throughout the service.

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "We treat everyone the same, and everyone is treated with dignity and respect." Another staff member said "Staff are mindful of racism or sexism and respect peoples' differences.

Good

Is the service effective?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in February 2017. At that inspection we found a breach of the legal requirements. This was because the provider had not ensured that mental capacity assessments were consistently in place for specific decisions.

At this inspection we found improvements had been made and that they now met the previous legal breach of regulation.

People told us that staff understood them and knew how to manage their health and social needs. One person told us, "They understand me, I can talk to them about anything." Another person said, "I think they are very good." Staff told us they were required to attend all the training and were supported by management with regular supervision.

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).

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people who lived at Quinnell House and we were made aware of people subject to DoLS authorisations. All staff had received MCA training. The service had completed appropriate assessments in partnership with the local authority and any restriction on the person's liberty was within the legal framework. We found that the service had submitted notifications to the CQC about the decisions of applications submitted for DoLS for people who used the service. A DoLS assessor was present at our inspection undertaking an assessment and was confident of the staffs understanding and referral process.

People received care from staff who had the knowledge, skills and experience to support them effectively. There was a robust induction for staff when they started work at the service. This included an introduction to the day-to-day routines, policies and procedures. They shadowed other staff to get to know people and the support they needed. Staff who were new to care completed the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. During this time, staff received on-going training and competency assessments. This included moving and handling, safeguarding and mental capacity.

All staff completed a rolling programme of essential training and competency assessments. Regular audits were completed to ensure staff received the relevant training. The registered manager told us they were

continually looking at different ways to provide and access training. Following feedback from staff the provider had moved away from just e-learning and now accessed face to face training from the Local Authority. For example, staff had received safeguarding training and had their competencies assessed. The registered manager and two senior care staff had received training to be medicine assessors this has enabled them to support staff effectively and ensured staff competency.

The introduction of champions in safeguarding, medicine, infection control had been supported by training and underpinned by a role description. This had proved beneficial to consistently drive improvement. There was a clear emphasis on improving staff knowledge and competencies. The registered manager had developed a competency framework for care staff. This was to develop their skills.

Staff received regular supervision from the registered manager. Supervision included an opportunity to discuss training, development opportunities, and review practice. Staff told us they felt supported by the registered manager and they would be happy to discuss concerns with any senior staff.

People's health was monitored and when required external health care professionals were involved to make sure they remained as healthy as possible. People's health needs were supported by a local GP surgery. The community older people mental health team were involved and advice sought when required. One person told us, "I see my doctor." Another said, "I go to the hospital to have blood taken." Where required people were referred to external healthcare professionals, this included the dietician and the diabetic team. People were regularly asked about their health and services such as the chiropodist, optician and dentist were offered. Visiting healthcare professionals told us people were referred to them appropriately. One health professional said, "Really good team of staff, they know their residents well."

People were supported to eat and drink enough to maintain a balanced diet. They told us they enjoyed the food and had enough to eat and drink throughout the day. One person said, "Food is very good, good choices and plenty to eat, too much." Other comments included, "The food is good, there's good choices as well," and "There's plenty to eat, more than enough and lots of choice of drinks." Nutritional assessments were in place and identified if anyone was at risk of malnutrition, dehydration or required a specialised diet. Information about people's dietary requirements were in their support plans and in the kitchen, for the cook. Information for the cook was updated daily so they were aware of people's individual requirements. A choice of meals was offered and alternatives were available. Where necessary people's food and fluid intake was recorded. We saw staff offer drinks throughout the inspection and not just at certain times." One staff member said "The kitchen is always open."

Most people chose to eat their meals in the dining room and the menu for the meal was displayed on a blackboard. The table was laid with condiments and cutlery. People were able to sit where they wanted to and we observed people felt comfortable eating at their own pace and in their own time. This made mealtimes a sociable occasion. Meals were homemade, well presented and looked nutritious. People's individual preferences were taken into account. When people had finished their meal staff checked they had eaten enough and second helpings were offered. There was a choice of hot and cold drinks available throughout the day and fresh fruit was available in the dining room. Homemade cakes were available in the afternoons. Everyone we spoke with said they enjoyed their meals. People said the food was very good and that they had plenty of choice. Staff regularly offered drinks and snacks outside of mealtimes, and this included fruit segments. Staff supported people who needed help with eating and who needed encouragement to swallow; this was done gently and in a kind caring way.

Meal times were flexible, for example people had breakfast at a time that suited them throughout the morning and staff ensured their lunch was then available later. Food and fluid charts were kept for those

people identified who were at risk from not eating and drinking enough. These were in the main completed accurately and used to inform staff to encourage food and drink and seek advice from the dietician and GP. Staff monitored people's weights monthly and the registered manager had an overview of everyone's weights and sought expert advice and support quickly. One person who was losing weight gradually had been referred to the GP and supplements had been prescribed. There was also evidence of people being supported by the community dietician. We spoke with a member of the community team who told us, "Very good at contacting us and they follow our advice." People with complex needs in relation to their eating and drinking had these identified and managed well. There were assessments completed to reduce the risk of choking and dietary supplements, fluid thickeners, and fortifications were seen to be in use. The food for people who required a pureed diet was seen to be of the required consistency and staff assisted them in a competent way.

Staff worked together to ensure that people received consistent and person-centred support when they moved from or were referred to the service. Pre-admission assessments were previously conducted at people's homes, but the registered manager preferred to now invite people to come to the service so they got a more accurate assessment and observed what the person was like outside their usual environment. If people were transferred to hospital, the person was sent with all their medicines. There was transfer documentation which held information such as allergies, medical history, capacity, mobility, any injuries, what jewellery people may be wearing, if they had epilepsy, their current weight, and whether the person was prescribed warfarin. The manager would ensure that the next of kin was contacted to inform them and also ensure that medicines charts and any instructions on resuscitation were sent. When accepting new people to the service the manager would ensure a discharge summary was sent from the hospital or care setting and check medicines had been returned and any changes were reflected in paperwork.

People's needs were met by the adaptation, design and decoration of the premises. The service was well decorated, with good lighting and wide corridors. The environment encouraged independence and orientation for people; signs and coloured corridors enabled this. People chose the lay out of their own rooms. Communal rooms had televisions and used them for exercise classes and playing music. During the inspection staff were singing along to the songs with people. Lighting in the service was well thought out and had been adapted to make it easier for people to walk around corridors at night time. The garden was accessible to people in wheelchairs. We observed people sitting in the garden and enjoying the good weather.

Good

Is the service caring?

Our findings

At the last inspection, this key question was judged to be good. This inspection found that it remained good.

We observed many caring interactions between staff and people during our inspection. There was a relaxed atmosphere within the home and we saw people approach staff for support and company throughout the inspection. One person told us, "Very kind." People told us they were treated with respect and their dignity maintained. One person said, "I am very happy here and everyone s very kind."

People were supported by staff who knew them well and had a good understanding of their needs. They knew what was important to people as well as their support and care needs. Relationships between people and staff were positive and caring. Staff had a caring approach and were patient and kind. They had time for people, their interactions were warm and friendly and they looked approachable. Throughout the inspection, we observed staff checking with people to ensure they were okay or if they needed any support. Staff also sat with people chatting, assisting them with music choices and engaging in one to one activities such as playing cards and knitting.

Staff were intuitive about people's emotional needs as well as their physical ones and responded in a genuine way. The purpose of the service was to support people who lived with dementia. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of appropriate humour throughout the day. The inspectors were introduced to people and to staff. Staff took time to explain the purpose of our visit to people and sought their consent for us to speak with them.

Staff told us how each person preferred to communicate and shared any special methods of communication. Staff also told us of how they supported those who cannot verbally express themselves, "We observe how people response to open questions and learn how they express themselves." We were told by staff 'when (name) does this', 'it means this' and then they detailed how they support the person, One care staff member said, "We communicate in different ways with different people, some people respond to quiet voices, some respond better to female care staff and others respond to pictures." Understanding peoples' specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care. For example, one person and staff ensured that they maintained eye contact and spoke slowly to ensure that picked up head and eye responses. One staff member said, "They can't talk but can still tell us what they want. We make sure we ask questions clearly, in a way that only needs a yes or no."

Staff spoke about people in a caring and respectful way. Care plans reflected how staff should support people in a dignified way and respect their privacy. People and their families or representative were involved in developing their care plan. Records showed where appropriate, people relatives and advocates signed documents in support plans to show they wished to be involved in the plan of care.

People's support records included an assessment of their needs in relation to equality and diversity and

dignity and respect. Staff we spoke with understood their role in ensuring people's needs were met in this area. We saw that staff had been trained in equality and diversity. All of the people we spoke with told us that staff treated them with dignity and respect, particularly when they were delivering personal care. People were supported in an individualised way that encouraged them to be as independent as possible.

The registered manager informed us people, relatives and their representatives were provided with opportunities to discuss their care needs on a monthly basis, more often if it was required. The registered manager also stated they used evidence from health and social care professionals involved in the person's care. Examples of the involvement of family and professionals were found throughout people's care plans, in relation to their day to day needs.

People looked relaxed and comfortable in their home. They were able to make choices about where they spent their time and going out. People were supported to maintain their personal and physical appearance. People were dressed in their own chosen style. For example, some people preferred casual clothing whilst others enjoyed dressing up, with makeup and jewellery. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "Really kind and caring." When people's needs changed, staff responded to and continued caring for people to meet their needs with compassion and understanding. One person told us, "I can't fault them."

People who lived with dementia were treated with respect, patience and kindness. We saw staff approach people who were restless and becoming agitated with a calm, friendly and affectionate manner. The response from one person was to smile at the staff member and hold their arm and walk to the lounge area.

People were supported to express their views and make informed choices about their care. We observed staff supporting people throughout the inspection, they took their time when giving people the information and explanations they needed and the time to make decisions. Preferences in relation to their personal care were recorded, for example, how they liked to take their bath and what were their preferred times for waking and going to bed. There were instructions for staff to refer to, advising them on the level of support required and where people were able to do tasks independently. Where people needed prompting, the level of prompt was recorded. This allowed people to maintain a level of independence and have some control over aspects of their lives.

People' rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones if they chose to. There were items of interest from the provider on notice boards, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed staff worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us they had regular visits from their church and felt her spiritual needs were respected by staff. They told us, "I like to take Holy Communion and they arrange it."

We read recent compliment cards and letters received in the home. They told us that people and families

were grateful with the support given to their loved ones.

Good

Is the service responsive?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in February 2017. At that inspection we found improvements were required in providing person centred care and the prevention of social isolation. This inspection found that improvements had been made.

People and their relatives were involved in developing their care, support and treatment plans. One person said, "Yes I get the care I want, I shower every day I think and see the Hairdresser," and "Very good, they look after me here." Due to people living with dementia not everyone knew of their care plan, but we saw evidence that families and advocates of people were involved as much as possible.

Senior staff met with people before they moved in to ensure staff at Quinnell House could meet their needs. We looked at the most recent arrival's care plan. The admission was well recorded and evidenced that the person was involved in the process. The care plan contained a good level of information that guided staff to deliver the care the person needed and in a way the person wanted. Care provided was individual and focused on peoples' individual needs.

The service used electronic care planning records and each person had a care plan in place. Care records were detailed and evidenced that staff knew people well. Levels of need were clear, for example, where someone had very complex needs they had been assessed as 'very high dependency needs'. Night routines were clear, describing all care that needed to be given to support them. Other care records detailed their interests and gave staff information that they could use to engage with them. Staff had a good understanding of people's needs and could describe care needs well. They received updates about each person during the daily shift handover. We joined one handover session which showed that staff discussed everybody and how they were and identified those that needed encouragement with food and fluids. Staff said they felt the handovers were beneficial especially if they had been off duty for a few days.

Activities were led by an activity team and there was a varied programme which included pampering sessions, for both ladies and gents and their families, exercise games, crafts and musical events. People and relatives said that activities suited individual 's interests, although some people didn't find them challenging enough. We observed the activity coordinator running an activity, which involved throwing a hoop over a target. People were laughing and smiling and getting involved. The activity coordinator explained that she moved around the lounge and did this with small groups of people to engage everyone. She explained that they visited the cinema every month during the dementia friendly screening which people really enjoyed, there was afternoon tea for families every Thursday and the dog therapy person visits every two weeks. She also told us "We run a baking club, a walking club exercise and mobility club and I visit people in their rooms. I do the tea round so I get to chat then. If people are at the end of their life I give hand massages and/or read to them." It was acknowledged that some records needed to reflect the one to one sessions in more depth. A relative said: "There are lots of activities but mum finds it is a bit childish for her." The relative also mentioned however that her mum was able to choose activities she did like. Another relative said "They bring in the dog, people like that."

There was a sensory room to help people with mental and sensory impairments. Music was playing in all areas where people sat; and if people wanted a quiet place they could return to their room at anytime or sit in the dining room. One visitor said, "A quiet room might be beneficial for some people." We passed this observation to the management team.

A hairdresser visited the service regularly and this was appreciated by people. One person said, "Its lovely to have my hair done, makes me feel good." Representatives from the local church visited for services during the year, such as Easter and Christmas and one person said, "The church minister visits me." Although no one living at the service was receiving end of life care at the time of our inspection, the home lead provided an assurance that people would be supported to receive good end of life care to ensure a comfortable, dignified and pain-free death. Senior staff confirmed they worked closely with relevant healthcare professionals, such as the local palliative care team, GP and district nurses and provided support to people's families and staff as necessary. We saw complimentary letters from families thanking staff for the lovely care their relative had received at this time. The care documents contained information about people's wishes at this time and these were supported by a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms for some people. DNACPR forms are where a medical decision is made by a doctor with the person or their representative.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We looked at what arrangements the service had taken to identify, record and meet communication and support needs of people with an impairment, disability or sensory loss. Support plans seen confirmed the management team's assessment procedures identified information about whether a person had communication needs. These included what the person required, for example, large print to read. This was to ensure people who lived at the home had access to information in different formats, such as large print. We saw staff communicating with one person by writing on a mini whiteboard which enabled the person to read what had been written and respond appropriately.

A complaints procedure was in place that was readily available to people and relatives. The procedure was displayed in the communal area and given to people when they moved into the home. We looked at the complaints file and saw that complaints managed in accordance with the provider's policy. We read the details of a recent complaint and the actions required had been checked and followed up by the registered provider. The people we spoke with had not had a reason to make a complaint, but felt confident they could do so if needed. Comments included, "I know (manager) I sent a letter to him, it was sorted straight away," "If there's any problems I only have to say and it's sorted," "If there were any issues I'd talk to staff that day, haven't had to, but I think they would sort it straight away," "Can speak to any of the staff they'd be there before you could turn around." A visitor told us, "They are quick to act. I told them the chair wasn't desirable, the next day it was replaced." Records showed complaints had been investigated (records maintained) and the complainant had received a written response. There was a complaint procedure displayed in the dining room and in the reception area.

Requires Improvement

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection in February 2017. At that inspection we found a breach of the legal requirements. At that inspection we found that aspects of provider's leadership required improvement, as we found continued shortfalls in relation to accurate and complete records not being maintained. This inspection found that improvements had been made, however, there were still some improvements required to improve outcomes for people and embed good practice in to everyday care delivery.

Quality monitoring system had been continuously developed within the home since the last inspection. There were detailed action plans that the registered manager had put in place with information gained from audits. For example, medicine audits had identified shortfalls and the registered manager immediately investigated and staff received further training and a competency test and this was also recorded in their staff files. The registered manager told us "We are constantly auditing and listening to others feedback to support us to develop as a service and push our service forward. We are all proud of what we have achieved and have a passion for continually improving." During the inspection we found that there were some areas that still needed to be developed such as the management of diabetes, consistent recording of activities and fluids. Immediate action was taken and therefore risk was seen to be mitigated. The registered manager was aware of the areas that needed to be developed and actions plans were in place.

People were regularly asked for their feedback about the service. This happened informally throughout each day when staff spoke with people whilst supporting them. People and their families were also involved in meetings where they could discuss their experiences at the service and highlight areas, which could be improved. For example, food and activities. Staff attended regular staff meetings to discuss the service, people and training needs. Feedback from staff supervisions had identified to the registered manager that staff did not like e-learning and would prefer some face to face training. Actions to rectify this were taken by the management team. Staff were signed up for face to face training with East Sussex County council, staff said this had a positive impact as they felt they learnt and retained a lot more information from face to face training. The provider had arranged for staff to attend train the trainer courses. This would benefit the service as training would then be in-house and available continuously for their staff. The registered manager and two members of staff had completed training to be medicine assessors and moving and handling assessors. This had ensured good medicine practices and competencies. Further staff were to be trained to deliver training in safeguarding. These roles were to be linked to the champion roles.

We asked the registered manager to tell us what they were proud of, he told us "We are passionate about delivering a high standard of support to achieve the best outcome and quality of life for our residents, we have come a long way and we have plans to develop our service further, especially with training and having our own agency of staff to cover our homes and reduce the use of agency staff, this means more consistency of staff and we will know they are well trained."

There was a positive, open and person centred culture at the service. The registered manager was visible and worked at the service five days a week. He had a good understanding of people and their individual

support needs. He met regularly met with people and attended daily meetings which ensured they remained up to date with people's needs. We observed the manager and deputy interacting with people, their relatives and other staff with kindness, humour and compassion. It was clear, through these interactions, that they had the best interest of people in mind and that they knew people well and spent time with them. The registered manager and deputy manager were present around the home and attuned to the needs of people. The manager laughed and joked with people during lunch, making them feel special and the deputy manager sat and ate her own lunch with people, chatting and laughing with people. During busy times, such as at lunchtime, they helped and led their team; leading and modelling positive interactions with people. There was also one exceptional staff member who had positive relationships with people and whom led the service at lunchtime. This was fed back to the management team. People told us, "They are very kind, I get upset, I cried and then I cheered up. The managers help me. They are kind nice people, and "I feel happy living here, staff and the managers are kind."

There was evidence of close working between the registered manager, deputy manager and provider to improve and develop the service. The registered manager told us, that they had an open-door policy which this has really supported the home to be able to rectify any concerns before they become bigger issues and offer support in any areas where it may be needed. The registered manager believed that this had allowed peoples' voice to be heard and that people knew their opinion really matters to the service and that we have listened to what they had said say and acted on it.

Staff told us they enjoyed working at the service. They said there was good teamwork and the management team and their colleagues were supportive. One staff member said, "We have a good team, things are much better with the new management style." There was evidence of good communication at the daily meetings where staff demonstrated a good understanding of people's needs and their roles and responsibilities. There was on-going communication across the team and staff were regularly updated about people's needs at handover and resident staff meetings.

Staff were involved in the development of the service. The registered manager told us they had worked with staff to develop the ethos and values at Quinnell House. The values were discussed as being, honest, and putting the residents at the heart of the service and continually driving improvement and development. Throughout the inspection, we saw these values were embedded into staff practice.

Staff had access to policies and procedure, for example, whistle blowing, safeguarding, infection control, health and safety, in accordance with best practice and current legislation. This helped to promote the safety and quality of the service along with quality assurance systems and processes to maintain and drive forward improvements. Staff had a good understanding of equality, diversity and human rights gained through training and detailed policies and procedures. Feedback from staff indicated that the protection of people's rights was embedded into practice. Up to date sector specific information was also made available for staff, including guidance around the Mental Capacity Act 2005 and updates on available training from the Local Authority. We saw that the service had also liaised regularly with the Local Authority, the Dementia In-Reach Service and Clinical Commissioning Group (CCG) to share information and learning around local issues and best practice in care delivery. The registered manager told us, "Learning is integral to our service."

We saw evidence that the service worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. External health care professionals we contacted informed us the service was well managed and people received a good standard of care.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks

regarding Quinnell House. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

From April 2015 it was a legal requirement for providers to display their CQC rating. The rating from the previous inspection for Quinnell House was displayed for people to see.