Care Quality Commission

Wellburn Care Homes Limited

# Eighton Lodge Residential Care Home

## Inspection report

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## Ratings

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

## Overall summary

This inspection took place over two days, 26 and 27 February 2015. The first day of the inspection was unannounced. We last inspected Eighton Lodge Residential Care Home in November 2013. At that inspection we found the service was meeting the regulation we inspected.

Eighton Lodge Residential Care Home provides personal care and accommodation for up to 47 people, including people living with dementia. At the time of the inspection there were 46 people living at the service.

The home did not have a registered manager, as the manager in post was awaiting the outcome of her application for her CQC registration. Following our inspection, the manager received her CQC registration. A

# Summary of findings

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's medicines were not always stored securely and we found some medicines records were inaccurate and not always complete. The service's arrangements for the management of medicines did not protect people.

Staff recruitment practices at the home did not always ensure that appropriate recruitment checks were carried out to determine the suitability of individuals to work with vulnerable adults, placing service users at risk of harm. Satisfactory reference checks had not been conducted and information on an application for employment form was incomplete. We saw security checks had been made with the Disclosure and Barring Service (DBS). These checks help employers make safer recruitment decisions and prevent unsuitable persons working with vulnerable people.

Staff were attentive when assisting people and they responded promptly and kindly to requests for help. People living at the home had risk assessments in place to ensure risks were identified and appropriately managed.

There were enough staff to meet people's needs. Detailed procedures and information was available for staff in the event of an emergency at the home.

Staff understood what abuse was and knew how to report abuse if required. The service had a whistleblowing procedure which meant staff could report any risks or concerns about practice in confidence with the provider.

People using the service told us they were well cared for and felt safe with the staff who provided their care and support.

All the relatives we spoke with were positive about the standards of cleanliness in the home. A relative told us, "It's a nice home; always clean."

We found there were gaps in the provision of training for all staff. This meant people were at risk of unsafe working practice from staff who did not have the skills and knowledge to consistently meet their needs.

Staff received regular supervision and annual appraisals were carried out. All new staff received appropriate induction training and were supported in their professional development. Staff told us they felt equipped and supported to carry out their roles.

The provider had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy and detailed information was available for staff. The requirements of MCA were followed and DoLS were appropriately applied to make sure people were not restricted unnecessarily, unless it was in their best interest.

People were supported to keep up to date with regular healthcare appointments, such as GP's, dentists, nurses and other primary care services.

People were supported to make sure they had enough to eat and drink. They told us they enjoyed the food prepared at the home and had a choice about what they ate.

People told us that staff treated them well and we observed kind and caring interactions between staff and people using the service.

Staff acted in a professional and friendly manner and treated people with dignity and respect. We observed staff supporting people and promoting their dignity wherever possible.

Meetings for people using the home and their relatives were held to enable them to express their views about the service. Advocacy information was accessible to people and their relatives.

Care plans were regularly reviewed and evaluated. They contained up to date and accurate information about people's needs and risks associated with their care. Family members we spoke with said they had been involved in care planning and told us there was good communication within the home. People we spoke with told us they saw health professionals when they needed to and a G.P. from a local practice visited the home every Friday to conduct people's reviews.

A complaints policy and procedure was in place. People told us that they felt able to raise any issues or concerns. However, we found the provider's policy was not always followed.

# Summary of findings

The home employed a full-time activities co-ordinator. People and their relatives were complimentary about the range of activities available and how people were engaged and stimulated at the home.

The service had a manager who spoke positively and enthusiastically about her role. She told us she was keen to develop her role and help ensure people continually received good quality care and support.

Management regularly checked and audited the quality of service provided and made sure people were satisfied with the service, care and support they received.

Care staff told us the management team were approachable and supportive. We received positive feedback from people, their relatives and staff about the management team and how the service was managed and run. Staff meetings were held regularly.

During our inspection we identified a breach in two regulations. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not always safe. Medicines records were not always accurate or complete and the service's arrangements for the management of medicines did not protect people. People's medicines were not always stored securely.

Staff recruitment practices at the home did not always ensure that appropriate recruitment checks were carried out to determine the suitability of individuals to work with vulnerable adults. One staff member's application for employment was incomplete and one reference did not confirm their suitability for employment.

People living at the home had appropriate risk assessments in place to ensure risks were evaluated and appropriate care and support identified.

There were enough staff to meet people's needs. People using the service told us they were well cared for and felt safe with the staff who provided their care and support.

**Requires Improvement**

**Is the service effective?**
The service was not always effective. We found there were gaps in the provision of training for all staff. This meant people were at risk of unsafe working practice from staff who did not have the skills and knowledge to consistently meet their need.

Staff told us, and records we examined showed that regular supervisions and annual appraisals were being carried out. All new staff received appropriate induction training and were supported in their professional development.

The provider had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy and detailed information was available for staff. The requirements of MCA were followed and DoLS were appropriately applied to make sure people were not restricted unnecessarily, unless it was in their best interest.

People were supported to keep up to date with regular healthcare appointments, such as GP's, dentists, GP's, nurses and other primary care services.

People were supported to make sure they had enough to eat and drink and told us they enjoyed the food prepared at the home and had a choice about what they ate.

**Requires Improvement**

**Is the service caring?**
The service was caring. People told us that staff treated them well and we observed kind and caring interactions between staff and people using the service.

**Good**

# Summary of findings

Staff acted in a professional and friendly manner and treated people with dignity and respect. We observed staff supporting people and promoting their dignity wherever possible.

Meetings for people using the home and their relatives were held. Advocacy information was accessible to people and their relatives.

### Is the service responsive?

**Requires Improvement**

The service was responsive. Care plans were regularly reviewed and evaluated. They contained up to date and accurate information on people's needs and risks associated to their care.

A complaints policy and procedure was in place. People told us that they felt able to raise any issues or concerns. However, we found the provider's policy was not always followed.

The home employed a full-time activities co-ordinator. People and their relatives were complimentary about the range of activities available and how people were engaged and stimulated at the home.

### Is the service well-led?

**Good**

The service was well-led. The service had a manager who spoke positively and enthusiastically about her role. She told us she was keen to develop her role and help ensure people continually received good quality care and support. Following our inspection, the manager received her CQC registration.

Management regularly checked and audited the quality of service provided and made sure people were satisfied with the service, care and support they received.

Care staff we spoke with told us the management team were approachable and supportive. We received positive feedback from people, their relatives and staff about the management team and how the service was managed and run. Staff meetings were held regularly.

Care Quality Commission

# Eighton Lodge Residential Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place over two days, 26 and 27 February 2015. The first day of the inspection was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor 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.

Prior to the inspection we reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority commissioners for the service and did not receive any information of concern.

We spoke with eight people who used the service to obtain their views on the care and support they received. We also spoke with six relatives who were visiting the home on the day of our inspection. We also spoke with the manager in post, the deputy manager, one team leader, 10 care assistants and the provider's activity coordinator. Following the inspection we spoke with a local authority commissioner for the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of care records. These included care records for six people who used the service, all 46 people's medicines records and five records of staff employed at the home, duty rotas, accident and incident records, policies and procedures and complaints records. We also looked at minutes of staff and relative meetings, premises and equipment servicing records and a range of other quality audits and management records.

Requires Improvement

# Is the service safe?

## Our findings

We looked at how medicines were handled and found that the arrangements were not always safe.

We examined all 46 Medicine Administration Records (MARs) for people living at the home and observed part of the lunch time medicine round. Overall, we found some issues with information in the MAR file. Although the file itself was neat and tidy, with no loose pages; the list of authorised signatures was out of date and a number of photographs of people were not attached to the MARs. A current photograph for each person helps to prevent errors and ensure medicines are not being given to the wrong person. We also noted another person's allergies indicator section was not completed. Most of the medicine administration was recorded correctly; however there were a number of omissions relating to two people's medicines in the month prior to our inspection.

We observed the medicine round and identified some concerns. We found the staff member conducting the lunch time medicines round acted professionally with people as they administered medicines. However, we were concerned that safe practices were not being followed regarding dispensing medicines security. We observed the senior care assistant responsible for administering medicines pre-potted (secondary dispensed) three doses of dispersible paracetamol into glasses of water and left them unattended in the treatment room to dissolve before administration. This meant the medicine had been removed from the original container, left unattended and not immediately administered to the person.

We also observed that the staff member conducting the medicine round left the open unlocked drugs trolley unattended in the treatment room and failed to lock the treatment room door, before leaving with each person's medicine. During the inspection we prompted the staff member to consider locking and securing the treatment room door. The senior care assistant said, "It's ok, none of the residents would go into the room anyway." This meant medicines were insecure, accessible to vulnerable people and were not stored safely and securely.

We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found no evidence of an over reliance on 'when required' (PRN) medication. The deputy manager told us no people were being given their medicines covertly at the time of the inspection. One person told us, "They look after my pills and see that I do not forget to take them."

Staff recruitment practices at the home did not always ensure that appropriate recruitment checks were carried out to determine the suitability of individuals to work with vulnerable adults, placing service users at risk of harm. We examined five recruitment records for staff who had recently been employed at the home and found four records detailed adequate recruitment checks had been conducted. However, we noted one recruitment record did not include two satisfactory references. One reference only confirmed their previous employment and not their suitability for the role and there was incomplete information on the application for employment form. Records confirmed that security checks had been made with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

People using the service told us they were well cared for and felt safe with the staff who provided their care and support. All the relatives we spoke with were happy with the care, treatment and support their relative received at the home. One person told us, "They (staff) come to you quickly when you want them." A relative we spoke with was complimentary about the quality of care received and said they were "completely confident" that their relative was in a safe environment.

We saw that where safeguarding incidents were identified, the majority of these were acted on appropriately and recorded for reference. We saw a safeguarding policy was available for staff to refer to. This included the procedure for making alerts and referrals, along with important local authority safeguarding adults team contact details. Staff we spoke with had a good understanding of safeguarding and knew how to report concerns. They were able to describe various types of abuse and were aware of potential warning signs. For example, if a person was 'off colour', any changes in their behaviour and a loss of appetite. Staff told us if they

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# Is the service safe?

had any concerns they would report matters directly to the manager. All of the staff we spoke with said they did not have any concerns about the care provided or the safety of the people living in the home. They told us they felt able to raise concerns and felt the manager would deal with their concerns immediately and effectively.

However, we noted in one person's daily care record, it was documented that there had been an incident of potentially inappropriate behaviour between this person and another person living at the home. We discussed the incident with the deputy manager who confirmed she was aware of the incident and this person's GP had been informed, along with the respective relatives of both people involved. We saw this incident had not been recorded in this person's care plan and the incident had not been referred and reported to the local authority safeguarding team. The deputy manager told us this would be addressed immediately.

We noted the service had a whistleblowing policy. Staff we spoke with were aware of the provider's whistleblowing policy and procedure. This meant staff could report any risks or concerns about practice in confidence with the organisation.

People, relatives and staff told us and we saw staffing levels were appropriate. We noted that there were sufficient staff to provide a good level of support to people. We looked at staffing rotas for the current and previous weeks and saw staffing levels reflected what we were told by the manager and deputy manager. One person told us, "There always seems to be plenty girls on; I never have to wait very long when I need help." Another person said, "They always come quickly if you need them." Relatives' comments included, "I think they could always do with another pair of hands; however they seem to cope very well," and, "My mother is happy with the staff (staffing levels) and I am happy." A care assistant told us, "Generally, there are enough staff on duty."

Throughout our inspection we saw staff were attentive when assisting people and found that they responded promptly and kindly to requests for help. We also saw staff would pay attention to people when they were spoken to, listened carefully to what they had to say and regularly sat with people and chatted with them.

The manager and deputy manager told us accidents and incidents were reviewed and monitored monthly. This was to identify possible trends and to prevent reoccurrences. We were told where appropriate, care plans and risk assessments would be reviewed to ensure people were kept safe.

People living at the home had appropriate risk assessments in place to ensure risks were identified and reduced. For example, care records we reviewed identified risks in relation to nutrition, mobility, safe moving and handling and falls risks. We saw that where external professionals had been involved in supporting people, for example, the district nurse and GP's, their assessments and advice had been incorporated into the risk assessments.

We saw that personal emergency evacuation plans (PEEPs) to describe how people should be evacuated out of the building in the event of an emergency were documented and in place for each person at the home. These were up to date, complete and contained a photograph of each person, along with other important information. For example, the preferred method of moving, their gender, weight and whether they could leave the building independently, or whether they required a wheelchair, or walking stick or frame. We also noted comprehensive and detailed contingency plans were in place in case of a fire, flood, loss of utilities, or other emergency. The manager told us, and records confirmed that the provider operated an out of hours contact facility where staff were able to contact a duty manager for advice and in the case of emergencies.

People and their relatives told us they were happy with the condition, presentation and cleanliness of the home. All the relatives we spoke with were positive about the standards of cleanliness in the home. A relative told us, "It's a nice home; always clean." A domestic member of staff told us about the importance of having high cleaning standards and how the bathrooms and toilets were regularly disinfected. We found the home was clean and no unpleasant odours were evident in any part of the home.

# Is the service effective?

## Our findings

We reviewed the training arrangements that were in place for the service. At the time of our inspection, 39 staff were employed at the home. The deputy manager told us mandatory training had been recently reviewed by the provider. Following the review, all staff were now required to undertake mandatory training in a number of areas which was to be refreshed annually. This was to increase the frequency of the training in order to improve staff understanding of the areas. These areas included emergency first aid, fire safety, health and safety, moving and handling, infection control and food hygiene.

The deputy manager told us, and available records confirmed, there were gaps in the provision of mandatory and safe working practice training and some staff training had lapsed and was out of date. This was despite the recent change to the frequency of some training. For example, 18 staff were overdue emergency first aid training; 35 staff were overdue fire safety training; 18 staff were overdue health and safety training; 25 staff were overdue moving and handling training, 14 staff were overdue infection control training and 22 staff were overdue food hygiene training.

The manager and deputy manager told us, and records confirmed seven staff members were booked to attend health and safety training in February 2015 and with the exception of food hygiene training which had not been booked; some staff were booked to attend moving and handling, infection control, fire safety and emergency first aid in March 2015. The manager told us it was her intention that outstanding and overdue training by all members of staff would have been undertaken and completed by the end of June 2015.

This meant that people were at risk of receiving care from staff that did not have the necessary skills and training to meet their needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us all new staff received appropriate induction training. Staff we spoke with confirmed their induction period helped prepare them for their jobs and working environment before working unaccompanied.

Induction training had recently been reviewed by the provider. All new staff attended an initial three day induction course with the organisation's external training provider, followed by in-house training once DBS security checks had been received. A period of shadowing an experienced and established colleague followed, before working unaccompanied. Staff then undertook a 13 week induction period, where their suitability to perform their role was reviewed after 12 weeks. Following a successful completion of their induction, staff were enrolled on a level two or three diploma and embarked on gaining adult health and social care qualifications. The manager told us 68% of the current staff had achieved an adult health and social care qualification. Other members of staff were working towards other health care and management qualifications. Staff we spoke with told us they felt equipped and supported to carry out their roles, training opportunities were welcomed by the provider and they were supported in their careers and professional development.

The manager told us all five team leaders at the home had been enrolled in a Team Leader Diploma (Basic Management) and both herself and the deputy manager were enrolled on a National Vocational Qualification (NVQ) Level 5 diploma in health and social care management.

During our inspection staff told us, and records confirmed that one to one meetings, known as supervisions, as well as annual appraisals were conducted. Supervision sessions are used, amongst other methods to check staff progress and provide guidance. Appraisals provide a formal way for staff and their line manager to talk about performance issues, raise concerns, or ask for additional training.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

The deputy manager was able to demonstrate her knowledge and understanding of the MCA and awareness of the legal changes widening the scope of DoLS. We saw the provider had a MCA and DoLS policy and a MCA / DoLS file was available at the home. We noted that this

Requires Improvement

# Is the service effective?

contained detailed advice, guidance, MCA and DoLS forms, along with record keeping assistance and an accompanying letter of advice received from the local authority. The deputy manager told us, and records confirmed, nine DoLS applications had been made to the local authority and had been authorised within the last 12 months. Care records viewed showed evidence that mental capacity assessments were being completed consistently and regularly reviewed.

People were supported to keep up to date with regular healthcare appointments, such as GP's, dentists, nurses and other primary care services. People we spoke with told us they saw health professionals when they needed to and a GP from a local practice visited the home every Friday to review people's health. One person told us, "You don't have to go anywhere to see the doctor and there is no waiting."

Throughout the visit we saw people were offered choices and asked for their permission. For example, when being offered a mid-morning and mid-afternoon choice of drinks. At lunch time when one person decided they did not want the meal they had chosen, they were offered alternatives which included a different meal, or a choice of sandwiches. We saw staff were pleasant and gave people adequate time to consider and discuss their choice.

We spend time observing the lunch time experience at the home. We saw people were supported to eat and drink sufficient amounts to meet their needs. We saw a wide selection of food and refreshments were available for everyone. Meals were well presented and there was an enjoyable and relaxed atmosphere in the dining area. We observed staff consistently supported people, whilst promoting their independence. When people had finished their meals they were asked if they had finished or if they wanted an extra portion and this was provided to people who requested it. Where staff were providing support for people to eat or drink, we saw this was done in a personalised and dignified way, with staff providing encouragement to people throughout the meal.

All of the people we spoke with were complimentary about the variety and quality of the meals at the home. One person told us, "The food is always very good." Other people's comments included, "You get food just like home here," and, "I always get offered extras."

We spoke to the cook about how people's nutritional needs were met. They told us they were provided with a menu each month by the provider's dietitian. They told us they supplemented this with information from a file which contained people's food likes and dislikes, along with details of any allergies or food restrictions. We also noted specially designed yellow coloured 'dignity crockery' was available to promote people's independence with eating and drinking. This was equipment that had been developed for use by older people, people with a visual impairment and people living with dementia.

We were told no people at the time of the inspection required fluid balance monitoring, or special diets. There was evidence of Malnutrition Universal Screening Tool (MUST) assessments being completed. Care records examined showed people's nutrition and monthly weight monitoring was in place. We also saw staff regularly provided people with drinks and snacks between recognised meal times. For example, tea, coffee, fruit juice, biscuits, sandwiches and potato crisps.

The home is a Grade 2 listed building which is well appointed, furnished and decorated throughout. We noted that improvements had been made in order to make the home safer and accessible. For example, sloping ramps between different floor levels, radiator guards were fitted and hand and grab rails had been installed at key points around the home. One relative told us, "It's a traditional home." The home is set in attractive well-maintained grounds and we noted it had recently won best commercial premises and had been awarded first place in the local authority 'Gateshead East in Bloom' competition.

Good

# Is the service caring?

## Our findings

Due to their health care conditions, some people were unable to tell us about their experiences of living in the home. However, people we did speak with and their relatives spoke positively about the care and support people received. One person told us, "The staff are so kind and they have really helped me cope with going into a home." Other people's comments included, "The girls are very helpful and always want to get you things," and, "The girls are all very nice and they know what you like." All the people we spoke with were complimentary about the quality of the care. They described staff as kind and compassionate and considered them as friends. One relative told us, "Staff are always chatting to people about what they would like to do."

We observed good caring relationships between staff and people living in the home. Staff were seen checking on a regular basis if people needed support. Staff were observed providing reassurance to one person who had become anxious and distressed and was comforted sensitively. Another person had become concerned and a care assistant immediately sat with them until they became calm. One care assistant told us, "People choose what they would like to wear." Staff also told us how they promoted people's independence by encouraging them and allowing them to do things for themselves where they were able.

During both days of our inspection care staff were observed acting in a professional and friendly manner, treating people with dignity and respect. Staff we spoke with had a good understanding of the importance of treating people with dignity and respect. They gave us practical examples of how they delivered care and how they achieved this. For example, making sure people were dressed of their choice, ensuring doors and curtains were closed when assisting people with personal care, maintaining people's dignity and respecting their rights and choices. We observed one example where a person who had fallen asleep, was gently roused in a sensitive manner by a care assistant to tell them it was nearly lunch time.

Relatives we spoke with were especially complimentary and told us how impressed they were with the staff. They told us how well staff had developed good friendly relationships with the people who lived at the home. We observed staff interacted with people well. Staff took the time to stop and chat with people, listening carefully to what they had to say and showed a genuine interest. For example, one person was asked if they were too warm and would be more comfortable if a layer of clothing was removed before commencing an activity.

We saw staff knocked on people's doors before entering their rooms and ensured any personal care was discussed discretely with people and carried out in private. Another example included staff discreetly repositioning one person's clothing to maintain their dignity without drawing unnecessary attention to the incident.

We saw people's rooms were personalised. We saw they reflected people's individual taste and were personalised with items from their previous homes. For example, memento's and keepsakes which were reminders of important times in their lives and personal photographs taken throughout their lives and of family members.

People and relatives we spoke with told us meetings for people using the home and their relatives were regularly held, however these were not always well attended. One person and a relative both told us these meetings were informative and the manager took on board and was receptive to any matters raised. Where possible, action would be taken to address issues raised and where this was not possible, an explanation was provided. People's relatives were consulted about the service they received. This was done by means of a six monthly quality questionnaire which was sent out by the provider's head office, to obtain their views and feedback on important issues.

Staff had access to information about people's preferences, including their likes and dislikes. They said they also knew about people's preferences from talking with them. For instance, people's choice of clothing and preferred times for getting up and going to bed. Care records included details of the person's next of kin, GP, religion, other professionals involved in their care and a brief medical history. We also saw evidence within care records of a more detailed life history for each person.

We noted no information or contact details for advocacy services for older people and people living with dementia were on display on notice boards in the home. Advocacy ensures that people, especially vulnerable people, have their views and wishes considered when decisions are being made about their lives and have their voice heard on

Good

# Is the service caring?

issues that are important to them. We also noted that this information was not included in the provider's service user guide or their statement of purpose. This meant advocacy information was not always easily accessible to people and their relatives. We discussed this with the deputy manager on the first day of our visit. On the second day of our visit we noted both local and national advocacy information was clearly displayed on laminated information sheets in the reception area and other notice boards throughout the home. Both the manager and deputy manager told us this would be included in the provider's service user guide and their statement of purpose in the near future. The deputy manager told us no people were using an advocacy service at the time of the inspection.

Requires Improvement

# Is the service responsive?

## Our findings

Some people living at the home were able to tell us about their experiences. One person told us, "They know me and know when I'm not feeling well." Another person commented, "They help keep you clean and tidy."

All of the people and their relatives we spoke with told us they were aware of the complaints procedure and how to make a complaint. One person told us they had previously made a complaint and had requested changes in their care. This person told us the complaint had resulted in a positive outcome and it had been responded to quickly.

We saw the service had a complaints policy and procedure. This detailed the process that should be followed in the event of a complaint and indicated that complaints received should be documented, investigated and responded to within a set timescale.

We examined the complaints records for the service and saw three complaints had been received within the previous 12 months. However, we noted the service was not following the provider's own complaints policy and saw whilst records relating to the complaint were recorded; the investigation and outcome were not always clearly recorded. The service's policy indicated complaints should be recorded in a complaints file and an acknowledgement sent by the person receiving the complaint. Whilst there was evidence the manager or deputy manager had dealt with the three complaints received effectively, clear records were not available to confirm the complaints had been resolved, where possible to the satisfaction of the complainant, or any written or telephone response had been given to the complainant regarding the outcome. We discussed this with the deputy manager, who told us this would be rectified immediately. We were told the service had received a number of compliments within the last 12 months. However, we were told these were filed at the provider's head office and were not available at the time of our inspection.

The home employed a full-time activities co-ordinator and we saw that there were a good variety of activities on offer and advertised around the home. People and their relatives were complimentary about the range of activities available and how people were engaged and stimulated. During our visit we saw two people enjoying a pamper session and were having their nails painted. Other activities observed included people listening to music, enjoying videos and a well-attended sing-a-long session. People were able to enjoy a range of one to one and group activities in the home, which included puzzles and word games, reminiscence afternoons, quizzes, Tai Chi classes, aromatherapy and jewellery parties. The provider also had a mini bus which was used to take people on shopping trips and visits to local places of interest. One person told us, "The activity co-ordinator livens things up." Another person commented, "I really enjoy the trips out." A care assistant said, "The ladies enjoy being pampered."

One person told us that they had requested personal internet access and facilities be made available in their room and the home 'had gone out of their way' to facilitate this. This person also told us that following a request, art classes had been arranged.

The six care records we examined were recorded in detail from pre-admission to present day. The records were stored correctly, neat and tidy and the contents were clearly indexed. All records examined contained a pre-admission assessment and comprehensive set of care plans that reflected people's assessed needs. We noted senior care staff maintained the records and updated the care plans on a monthly basis. A daily report record for each person was kept in a separate file to allow for contemporaneous records of care. At the end of each month these records were transferred into each person's own care record file. We noted care records contained do not attempt cardiopulmonary resuscitation (DNACPR) forms, a photograph of the person and a completed 'hospital passport' section.

We found care plans were regularly reviewed, updated and evaluated and noted GPs, nurses and other health and social care professionals were involved in the review process where applicable. Family members we spoke with said they had been involved in care planning and told us there was good communication within the home. They also said they felt fully informed about any changes or developments in people's care and condition. Care plans described the person's needs, how their needs would be met and any potential risks associated with providing their care.

We noted one person who was living with dementia had a variety of dolls which they cared for affectionately during our visit. This is known as 'doll therapy'. Doll therapy is known to alleviate agitation and distress for people living

# Is the service responsive?

with dementia. It is also therapeutic and can become an integral part of a person's life and caring for the doll as they would care for a baby becomes a major part of their day to day responsibilities. We noted care staff asked this person which doll they required at the time, respected the 'dolls' and reacted in an appropriate manner to requests made.

Good

# Is the service well-led?

## Our findings

The manager currently in post at the home was awaiting the outcome of her application for her registration with the Care Quality Commission. She had joined the service in 2007 and had been manager since November 2014. The deputy manager had also been recently appointed. Both the manager and deputy manager spoke positively and enthusiastically about their roles in ensuring the care and welfare of people who used the service. They also told us they were keen to develop their roles to help ensure people continually received good quality care and support. People who used the service and staff were fully aware of the roles and responsibilities of managers and the lines of accountability.

The provider had submitted statutory notifications to the Care Quality Commission. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends, or concerns.

We discussed what checks the management team conducted and completed to ensure people were receiving appropriate care and support. We noted regular monthly audits were undertaken and these included fire safety checks, accidents and incidents at the home, care plans and risk assessments, medicines, door maintenance, emergency lighting and health and safety checks. We saw three monthly drills were undertaken for night staff fire drills, along with six monthly fire drill checks for day staff.

Staff we spoke with all told us staff meetings were held on a regular basis. Staff told us they were able to ‘speak up’ at the meetings and they felt confident they were listened to and able to discuss important matters. One care assistant told us, “We can raise issues at the meetings and regularly do so.”

We saw records were kept of equipment testing and these included fire alarms and firefighting equipment, electrical appliances, emergency lighting and the calibration of food thermometers. Other equipment and systems were also subject to checks by independent companies or assessors. For example, records showed hoists, slings and medi-bath lifts, passenger lift servicing, gas and electrical checks, asbestos management, fire safety systems servicing and checks were carried out at appropriate intervals. We noted that these were up to date, accurate and were completed regularly.

The manager and deputy manager told us the service did not currently work with, or have links to other organisations, to develop their knowledge, share good practice and ensure its service was up to date with national best practice standards. For example, memberships with the Alzheimer’s Society or Dementia Friends, in order to improve and develop the service provided. They told us they themselves had identified the need for the service to forge links with specialist organisations. They had conducted some initial research in order to access specialist care and related information regarding specific conditions some of the people they cared for may have. The manager told us she and the deputy manager were ‘Dementia Champions’ for the home. Dementia Champions are individuals who are committed to improving understanding and awareness of people living with dementia.

All care staff we spoke with told us they felt well supervised by both the manager and the deputy manager. They also told us they were confident they could approach them at any time and discuss any issues, both personal and work related they may have. Staff we spoke with said they felt equipped and supported to carry out their role and spoke of the manager operating an ‘open door policy’ and being approachable.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>People using the service were not protected against the risks associated with the proper and safe management of medicines.<br>Regulation 12 (1) (2)(g). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>People were cared for by staff who were not always supported to receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.<br>Regulation 18 (1) (2)(a). |