The Pinhay Partnership

Pinhay House Residential Care Home

Inspection report

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Ratings

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

Overall summary

Pinhay House residential care home is a grade two listed Victorian mansion, overlooking the sea, near Lyme Regis. The provider is a partnership with two partners. The home is registered to provide accommodation with personal care for up to 25 older people, some of whom are living with dementia. During our visit, there were 18 people at the service, two of whom were staying for a short period of respite care.

The inspection took place on 7 and 12 May 2015 and was unannounced. We last inspected the service in November 2013 and identified concerns about infection control, supporting staff and with record keeping. We received an action plan which showed the home would be compliant by January 2014.

The previous registered manager left in January 2015, a replacement manager was appointed in February 2015

Summary of findings

and their registration with the Care Quality Commission was completed on 25 May 2015. They are therefore referred to as the registered manager throughout this report. 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.

As part of the lease agreement, the provider was responsible for the maintenance and upkeep of the building. A number of risks related to the premises were identified during the inspection which needed to be addressed as a matter of urgency. This included a leaking boiler flue, water temperatures in bedrooms which exceeded the Health and Safety Executive recommended limits and the replacement of fire doors to meet regulations. This work was needed to update the premises to meet the needs of people and to comply with all statutory requirements. Following the inspection, we received assurance that work was underway to address the most urgent risks. Suitable and sufficient environmental risk assessments needed to be undertaken, particularly to identify further ways to reduce moving and handling risks for staff and people.

Although several staff had left the service recently, some experienced staff had been recruited and further recruitment was underway. People were supported so they could receive care at a time convenient for them by some staff working extra hours to ensure sufficient numbers of staff.

Staff demonstrated a good understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty.

Staff were knowledgeable about people's care needs and improvements in staff training were underway. People were supported to maintain their health and to access ongoing support from health care services. Health and social care professionals were positive about the care and support provided for people.

People were treated with dignity and respect and staff were caring and compassionate towards them. They were supported to express their views and be involved in decision making about their care.

People received care that was individual to their needs. Staff knew people well, about their needs and preferences and how they liked to spend their day. People were supported to remain active and independent and to pursue a variety of hobbies and interests. People's views were sought and improvements made in response to any concerns raised.

The service was well led and promoted a culture that valued each person and staff. People, relatives and staff said the home was well run and they had confidence in the provider and the registered manager. The home had a range of quality monitoring systems in place and had identified further improvements which were being implemented.

We identified one breach of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the 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?

Requires improvement 

Some aspects of the service were not safe.

People were not adequately protected from environmental risks.

Staff knew about their responsibilities to safeguard people and to report suspected abuse.

People received their medicines in a safe way.

People were supported by enough staff so they could receive care at a time convenient for them.

People were protected because recruitment practices were robust.

Is the service effective?

Good 

The service was effective.

Staff were supported by experienced staff who were knowledgeable about people's care and treatment needs.

Staff demonstrated a good understanding and acted in accordance with the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access healthcare services appropriately and staff followed professional advice given.

Is the service caring?

Good 

The service was caring.

People and relatives said there was a homely atmosphere and were positive about the caring attitudes of staff.

People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Staff were kind and compassionate towards people and formed positive caring relationships with them.

Is the service responsive?

Good 

The service was responsive.

People's needs were assessed and there were detailed care records in place to inform staff about care and treatment.

Staff knew people well, understood their needs well and cared for them as individuals.

People felt confident to raise concerns. Any concerns were listened to, investigated, and were appropriately responded to.

Summary of findings

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management, said the home was well run and had improved over the past few months.

People and relatives' views were sought and taken into account in how the service was run.

The provider had a variety of systems in place to monitor the quality of care and was making further improvements.

Pinhay House 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 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 7 and 12 of May 2015 and was unannounced. The inspection team comprised of one inspector.

All information known about the service was reviewed before the inspection including previous inspection reports, contact with the provider and notifications. A notification is information about important events which the service is required to tell us about by law.

We spoke with 13 people using the service, five relatives and friends and we looked in detail at five peoples' care records. We spoke with 16 staff, looked at five staff records, at training records and at the provider's quality monitoring systems.

Some people were not able to verbally share with us their experiences of life at the home because of their dementia. 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 comment directly on the care they experienced.

We sought feedback from health and social care professionals who regularly visited the home including GP's, community nurses, other therapists and commissioners and received a response from five of them.

Requires improvement

Is the service safe?

Our findings

People and relatives felt safe at the home. However, some aspects of the environment were not safe because of risks related to the premises.

A health and safety audit completed in November 2013 identified a number of high risk priorities particularly in relation to fire prevention. A specialist fire risk assessment of the home was also completed. Since then, the provider upgraded the fire detection system, improved fire escape signage and replaced the fire extinguishers. Staff had undertaken fire training, and a fire drill and another was planned. Personal emergency evacuation plans had been developed for each person living at the home.

However, the replacement of fire doors, identified as a high priority action, had not been completed. The provider explained this was originally due to start in June 2014 but has not yet commenced due to costs and delays with contractors. They confirmed the work was due to commence on 15 May 2015 and was phased to be completed by end March 2016. We contacted the Devon and Somerset fire and rescue service who confirmed this timescale was appropriate.

When we visited on 7 May 2015, there was an odour in the upstairs corridor area. The person living in the nearby bedroom had been temporarily moved to another room. The provider explained the lining of the flue from the boiler was leaking, which they were in the process of addressing. They said the work previously completed to upgrade the fire prevention measures, meant this did not affect any other bedrooms in the home. However, there was no written risk assessment in support of this, which we asked the provider to complete.

When we returned on 12 May 2015, a risk assessment had been completed. A carbon monoxide detector had been fitted in the corridor to alert staff to any noxious fumes. Since then the provider has contacted us to advise work is due to commence on 1st June to replace the flue liner and will be completed by 3rd June 2015.

A second person recently had to move rooms because of a ceiling leak. The provider and maintenance staff described ongoing work to renovate and upgrade each section of the roof. So far, nine of the 24 sections had been completed and the work was progressing as funds allowed. Any urgent roof repairs and replacement of slates was completed. as needed. Water tanks were old and leaked occasionally but maintenance staff assured us they were safe, had drip trays fitted and were monitored regularly.

People were at increased risk of scalding because water temperature checks showed the hot water supply in people's rooms was exceeded maximum temperatures recommended by the HSE. The provider confirmed thermostatically controlled valves were fitted in bathrooms but not in sinks in bedrooms. We immediately raised our concerns with the registered manager and provider and asked for further actions to be taken to reduce those risks. These risks had not previously been identified, although the health and safety audit highlighted a lack of suitable and sufficient environmental risk assessments.

Following the inspection, updated us on further actions taken to reduce these risks. An immediate test of all basin hot tap water temperatures was undertaken. A risk assessment was undertaken which identified people most at risk and caution signage has been displayed in all affected areas. A phased schedule of work has been planned to fit thermostatic blending valves to control the temperature of the hot water in bedroom areas, which is due to be completed by 31st July 2015.

People were at increased risk because of some moving and handling risks. We identified some unsafe moving and handling practices which put people and staff at increased risk of injury. For example, some staff assisted people to move by placing their elbows under people's arms to help them mobilise. This practice is not in accordance with Manual Handling Operations Regulations 1992 or Health and Safety Executive (HSE) guidance. We raised this with the registered manager and asked about moving and handling training. Practical moving and handling update training was last completed in 2013. The previous training provider had ceased trading and the provider said they had been able to identify a suitable replacement. Recently recruited staff had undertaken theoretical moving and handling training through watching a moving and handling DVD but had undertaken practical training previously in other services. in accordance with HSE guidance. This meant there people were at increased risk because some moving and handling practices at the home were out of date.

The registered manager agreed to take further steps to source some practical moving and handling update

Requires improvement

Is the service safe?

training for all staff as required by HSE guidance. On 12 May, when we next visited, the registered manager had identified a member of staff to undertake a moving and handling trainer's course. This would mean, longer term, they could train other staff and support moving and handling practice at the home . However, there was no risk assessment in place about how this risk would be managed in the meantime.

Although there were moving and handling plans in place, some lacked detail for staff about how to assist each person to mobilise safely. For example, we looked at moving and handling plan for a person who needed two staff to help them mobilise. They had recently been assessed by an occupational therapist in relation to their moving and handling needs and an electric bed had been purchased for them. However, their moving and handling plan did not include details about how to help the person to get into bed or how to assist them into the bath. Staff said they felt confident to assist this person to move and transfer around the home and described safe methods. Most people who lived at the home could mobilise using walking aids or a wheelchair to transfer. There were no staff moving and handling risk assessments to show whether environmental moving and handling risks for staff had been assessed. This meant we could not be assured all reasonable adjustments had been made for people and staff to reduce moving and handling risks as much as possible.

We discussed with the provider, registered manager and maintenance person about how environmental risks were managed. Previously the service had employed the services of a health and safety consultant to advise on health and safety. However, they had stopped providing the service a few months ago and has not yet been replaced. This meant some of the health and safety recommendations from the audit had not yet been implemented, such as the development of suitable and sufficient environmental risk assessments. The findings at inspection showed further work was needed to ensure health and safety risks were appropriately identified, risk assessed and prioritised.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider undertook to seek further health and safety advice to ensure environmental risks were being managed in accordance with the level of risk and with legislative requirements.

People's care records included individual risk assessments and where risks were identified, individual care plans were developed to inform staff about how best to meet them. For example, a falls risk assessment was completed for a person identified at increased risk of falling. This identified a range of further measures to try and reduce the risk of further falls. They included making sure the person had everything they needed at hand and encouraged them to ask staff for help when they mobilised.

A maintenance person worked five days a week at the home and there was a system in place for staff to report repairs and maintenance needed, which was signed to confirm when the work was completed. Recent environmental improvements had been made in the kitchen in response to recommendations from an environmental health visit. The service had been awarded a four star rating and were awaiting a revisit. Emergency contingency plans were in place to evacuate people in the event of a major loss of services.

A stair lift was fitted which helped people access some, but not all upstairs bedrooms in the home. Where people's mobility had deteriorated, they had been moved to rooms which were more accessible for them. Other equipment was available to help people mobilise independently, such as toilet raisers, frames over toilets and height adjusted chairs. Staff confirmed they had all the appropriate equipment they needed for moving and handling such as stand aids, a hoist and moving and handling belts.

Since the last inspection, improvements in infection control practices had been made and people were cared for in a clean, hygienic environment. Staff had access to hand washing facilities and used gloves and aprons appropriately. New cleaning schedules had been introduced and daily, weekly, and monthly cleaning records were maintained. Cleaning staff had suitable cleaning materials and equipment available. Regular checks of cleaning were undertaken to monitor and address any shortfalls identified. Some bathrooms had been redecorated and broken tiles replaced. In one bathroom, the metal feet on the grab rail around the toilet

Requires improvement

Is the service safe?

and on the foot of a bath hoist had some rust patches, which needed to be addressed. This was because rust makes it more difficult to clean equipment to prevent cross infection.

Soiled laundry was laundered separately at high temperatures in accordance with the Department of Health code of practice on the prevention and control of infections. The laundry had one washing machine and tumble drier which did all the laundry for the home including people's clothing and bedding. On the first day we visited, the tumbler drier was broken and the service was awaiting a contractor to visit, this was repaired when we next returned. We asked about this reliance on one piece of equipment. The provider advised there was an eight service hour service contract in place for all repairs, to ensure continuity of the laundry service.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. Staff worked in an unhurried way and were available to support people at a time and pace convenient for them. The provider used a dependency assessment tool for each person, which helped identify their staff support needs. This tool was regularly updated as people needs changed. Following the recent management changes, a number of staff had left, and new staff had been recruited, some of whom were still undergoing induction. The registered manager had identified a need for more staff who were skilled and experienced in providing care. Staffing rotas showed recommended staffing levels were being maintained. Further recruitment was ongoing and any gaps in the rota were filled by existing staff working extra shifts and by the registered manager, which staff appreciated.

Medicines were managed in a way that ensured people received them safely and as prescribed. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. The home used a monthly monitored dosage system on a monthly cycle. Medicines were checked each day and medicine administration records were audited weekly and action taken to follow up any discrepancies or gaps in documentation.

Medicines were securely stored in line with current regulations and guidance. For example, those which required refrigeration were stored appropriately and fridge temperatures were monitored to ensure they were kept at recommended temperatures. There were systems in place for recording all medicines received, unused stocks were returned to pharmacy for destruction.

Accidents and incidents were reported and reviewed monthly to identify ways to reduce risks for each person as much as possible. For example, where a person was identified at higher risk of falling, they were referred to the community 'falls' team for assessment to identify further strategies to prevent their risk of falling. Care plans were updated with any advice given and were reviewed regularly to evaluate their effectiveness.

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. Staff could report any concerns to the registered manager or provider and were confident they were dealt with. The provider had safeguarding and whistle blowing and policies available so staff were clear how to report concerns. One staff member had recently reported a staff concern, which was fully investigated and dealt with. This showed people were protected because concerns about suspected abuse were taken seriously and followed up.

Good

Is the service effective?

Our findings

The registered manager had undertaken a review of training provision at the home. The review showed some staff update training was overdue and a training improvement plan was agreed. In support of that, the provider invested in a range of new training materials recommended by the registered manager. Three staff were booked on a first aid 'train the trainers' course and another was due to undertake a moving and handling trainers course. At the time of the inspection, a member of staff leading the in service staff training programme had just left, which meant there would be a gap in progressing staff training. When we returned on the second day, the registered manager had identified another experienced member of staff to take the lead role for staff training.

The registered manager was compiling a new training matrix. When completed, this will provide an overview of all training staff are required to do, and show when training updates are due. This will enable the registered manager to more effectively monitor staff training. Staff said they had enough training to do the job although some staff said they would like more training, particularly in moving and handling. Staff files showed staff working at the home had previously undertaken a range of training and had qualifications in care or were undertaking them. For example, the deputy manager was undertaking a management qualification. This showed the provider was committed to further improving staff training opportunities at the home.

Staff induction was completed in accordance with the National Skills for Care induction standards. Two new staff said they had felt well supported during their induction. They had completed a range of training such as health and safety, infection control, food hygiene, safeguarding and had worked alongside experienced staff to get to know people's care needs.

Since the new registered manager started, about a third of staff had received individual supervision. Remaining staff supervision sessions were arranged and planned every eight weeks. Where there had been any concerns identified about individual staff care practice, staff records showed the registered manager had prioritised their training and supervision. Annual staff appraisals were due to be completed later in the year.

Each person had an assessment of their care and health needs and there were individual care plans in place to instruct staff about specific health needs such as about pressure area care, catheter care and nutritional needs. Health professionals visited the home regularly and spoke positively about people's care and treatment. They confirmed staff contacted them appropriately and carried out their instructions. One said "The care is good there", another said, "Information and communication is shared well and advice taken accordingly".

For example, there was a detailed behaviour support plan in place or a person who sometimes exhibited behaviours that challenged the service. This included information about the person's preferences, such as how they liked a daily routine and had their own seat at the dining table. Their behaviour support plan included any triggers for behaviours and how to avoid them, such as avoiding certain other people and responding quickly when they asked for help to go to the bathroom. Detailed records were kept to inform mental health practitioners involved in regular reviews of their care and medication and showed staff were acting in accordance with this plan.

People were offered day to day choices, for example, at lunchtime, staff brought two plates of food to show some people so they could indicate their preference. Records included detailed information about each person's communication support needs and how to help each person make choices, what aspects of day to day decisions each person could make for themselves and what aspects they needed support with.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and acted in accordance with them. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments were completed for each person who lacked capacity.

When people were assessed as not having the capacity to make a decision, there was evidence of involving family and people who knew the person well in decision making. Where 'best interest' decisions were made about people's care and treatment, the person, health professionals and relatives had been involved and consulted. For example, one person sometimes refused their medicines. Their GP had provided written authorisation for staff to offer them

Good

Is the service effective?

their tablets concealed in food or drink in their 'best interest'. This decision had been discussed and agreed with a family member who had power of attorney for decisions about the person's care and treatment.

Feedback from a mental health professional confirmed staff at the home acted in accordance with the Mental Capacity Act and Deprivation of Liberty safeguards. Referring to a recent contact with the home in relation to one person living with dementia, they said, "The care was excellent", and the persons' relative was well supported throughout. They said staff at the home communicated well, shared information and followed professional advice.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager had reviewed people at the home in the light the Supreme Court judgement on 19 March 2014, which widened and clarified the definition of deprivation of liberty. From this review, they had submitted 15 Deprivation of Liberty applications to the local authority DoLS team and were awaiting assessments of each person.

People and relatives praised staff support for people to remain as independent as possible and not restrict their movement around the home. Some people were assessed as able to safely go out unaccompanied whilst others needed staff or relatives to accompany them. A key pad lock was fitted to the main entrance, the code was on display for those who were able to use it. Other doors were unlocked in areas where staff were always present so that people could go outside where staff were on hand to assist them.

There was a lack of signage or symbols around the home to indicate where the bathroom and toilet areas were located. Very few people had visual prompts to help individuals locate their room, although people seemed to manage very well. One staff member commented the colour schemes didn't help people with dementia distinguish one area from another. We recommend the service explores further the relevant guidance on further steps needed to make the environment more user friendly for people living with dementia.

A nutritional assessment was undertaken on each person and a care plan was in place for anyone identified at risks of malnutrition or dehydration. People were offered a varied and nutritious diet and were supported to eat and drink at mealtimes and there was bowl of fruit and other snacks in the drawing room for people to help themselves to. In the kitchen, there was a list of people with food likes and dislikes and any dietary needs, such as about a person with diabetes and another who was a vegetarian. Two people were on a soft diet as they had difficulty chewing.

Detailed records were kept about eating and drinking for anyone at risk of malnutrition or dehydration, including monthly weight checks. Any issues such as weight loss were spotted and care plans updated in response to increase food and fluid intake as needed. For a person with a poor appetite, staff offered them smaller amounts of food more frequently. Another person was a very slow eater, staff didn't hurry the person but waited until they were finished their meal before offering them dessert.

Good

Is the service caring?

Our findings

People's relatives and friends described a very homely atmosphere at the home. They said they were always made to feel welcome whenever they visited the home. One said, "It feels more like mum's home rather than an institution" and described staff as "Friendly and loving". Another relative said, "Its brilliant, staff are good, family orientated, I wouldn't hesitate to recommend it".

Staff spent time with people and were compassionate and kind towards them. They sat down and chatted easily with people, knew about their family, their interests and what mattered to them. Staff demonstrated through their conversation with people and with us that they knew about each person, what they enjoyed and how they liked to spend their day.

Staff showed people mattered to them, they were aware of people's wellbeing, noticed when a person needed attention and immediately went to help them. They communicated well with people, anticipated their needs, and made eye contact when they spoke to a person. They waited patiently for them to respond to questions without interrupting or hurrying them. Care records included information about people's communication needs including whether people needed glasses or a hearing aid. For a person with poor vision, their care records showed they could recognise cutlery by its feel. This meant staff had the information they needed to support people to retain their independence as much as possible.

Staff responded calmly and patiently to each person, holding a person's hand and spending time reassuring them when they became confused or upset. On the first day we visited, one person was very distressed on several occasions following the departure of their dog who had previously lived at the home. Staff spent long periods with the person, and patiently repeated explanations about the dog's departure, comforting and reassuring the person each time they got upset. When we returned on the second day, this person was much happier and more settled.

Another person spent a lot of time in their room. They were surrounded by favourite objects and soft toys, staff left the door open so they could see what was happening. Staff regularly popped in to have a chat with the person as they passed by. At lunchtime, staff helped the person to wear a protector to protect their clothing. They had a special plate and adapted cutlery so they could eat independently, in accordance with their care plan. Staff helped the person to clean their hands and face after lunch to protect their dignity.

One person had a pet cat who lived in their room, which staff supported them to look after. A relative said they had "rebuilt their relationship" with their relative since they came to live at the home. They went onto explain they had previously been their full time carer but now they could enjoy spending time with them. They felt their relative was safe, well cared for and said staff were "so kind " to them.

People and relatives confirmed they were consulted and involved in discussions about their care and treatment and in updating their care records. For example, the relative of a person with deteriorating health told us the person did not wish to go to hospital. Recently, the person had become unwell, staff contacted the ambulance service and a paramedic attended. Staff acted as an advocate for the person, made sure their wishes about not going to hospital were communicated. These were recorded in the person's care records and their wishes supported by this person's GP. This meant their wishes were known, and relatives were pleased staff were able to keep the person at the home. Another visitor said staff kept in regular contact with them. They confirmed staff had involved them in decision making about whether a person's dog should no longer live at the home.

People's cultural and religious preferences were known and recorded. People's views about end of life care were sought and their wishes were recorded. A vicar who regularly visited two parishioners at the home described the end of life care offered to a person who recently died at the home as "phenomenal".

Good

Is the service responsive?

Our findings

People received care that was responsive to their individualised needs. A health professional said, "I think Pinhay House meets peoples individual needs well, taking into account their past history and life prior to placement". Relatives said staff knew people well, about their lives before they came to live at the home and their interests and hobbies.

People and relatives contributed to the assessment and planning of their care. Care plans accurately reflected how individuals said they liked to receive their care and support. This included information about what support each person needed and what they could do themselves. Care records included detailed information about each person's communication, physical and psychological needs and their levels of cognition.

Care records at the home had recently been reviewed and updated and had reverted to a paper based system. This was in response to feedback from a volunteer about how much time staff were spending on record keeping, which meant they had less time to spend with people. Care plans were reviewed and evaluated regularly as people's needs changed. Daily records were completed which provided information about the care provided, people's physical and psychological wellbeing, eating and drinking and about how they spent their day.

Care records included individualised information about each person's life before they came to the home and about their interests and hobbies. The provider used a "This is me" tool developed by the Alzheimer's society to gather individual information about each person's life from the person, their relatives and friends. For example, about how one person loved jazz music and playing the banjo and that another person had been a dancer. A relative of one person, who had limited sight and was often very sleepy, said how much they appreciated staff trying to engage and stimulate them. For example, by playing music from an old Laurel and Hardy film, and making sure they never missed their favourite weekly jazz programme.

The service had a programme of outside entertainment such as musical entertainment, and Tai Chi. Whilst we were visiting, people enjoyed listening to music, playing a ball game, reading their daily paper and art and craft activities. Digital photographs on display showed previous entertainment activities people had enjoyed and participated in. Following recent staff changes, two new activity co-ordinators had been appointed who were reviewing the activities programme and equipment available to see if any changes or improvements were needed.

People were encouraged to make their room homely and many people had furniture, photographs and other memorabilia in their room that was precious to them. One family had decorated their relative's room to be more 'dementia friendly' with lots of artwork to interest them. When their relative moved downstairs because of their reduced mobility, the provider agreed they could decorate a second room in a similar way. This meant their relative hadn't noticed they had moved rooms. One person told us how much they appreciated their afternoon walk around the grounds unaccompanied. Another person was very restless in the early evening and staff enabled the person to wander freely around different areas of the home. A reception desk in the main entrance area was widely used by staff and people. It provided a focal point for people to meet up with staff, ask questions and seek reassurance.

Staff had received 'dementia friendly' training. There was a reminiscence area where people could access a variety of memorabilia of interest and relevance for them. Sensory items and rummage boxes were available for people who liked to keep busy. There were a range of educational and reference books available for staff about the needs of people with dementia, and staff demonstrated a good knowledge of caring for people living with dementia.

People, relatives and staff said they felt able to raise concerns with staff, the registered manager and the provider about their experiences. The provider had a written complaints policy and procedure but had not received any formal complaints in the past year. Relatives were regularly asked for feedback and said their views and suggestions about the person's care were listened and responded to. The home had two volunteers who visited regularly, talked to people and participated in activities. One of the volunteers acted as a 'critical friend' to the provider. They told us that on one occasion , they were concerned about the attitude of a member of staff which they raised with the provider, and which was dealt with. Their observation about staff spending a lot of time on paperwork also resulted in improvements being made.

Good

Is the service well-led?

Our findings

The registered manager submitted their application to register with the Care Quality Commission which was processed during the period of the inspection and has since been confirmed.

People, relatives and staff were positive about the provider and the registered manager. They spoke about the culture of the home as being friendly and open. The provider said staff had been through a difficult period of change following management changes. They said they thought the culture of the home was now more open, and staff morale had improved over the last few months. Staff agreed with this view and spoke positively about recent changes.

The registered manager was in day to day charge of the home and spent a lot of time working with staff and monitoring care practice within the home. They were supported by a deputy manager and a senior care worker in charge of each shift. Staff said they felt well supported and confirmed the registered manager was visible around the home and was tackling any concerns. One staff member said they thought previously things had gone downhill but were now improving. Another member of staff said, "Everything is different, I look forward to coming to work" and a third said, "There is a vast improvement, what needs doing is getting done" Other staff spoke about feeling "well supported", one said, "Things run more smoothly, there is no atmosphere".

In February 2015, the provider sought the support of the local authority quality monitoring team to look at strengthening their quality assurance systems. A representative visited the home to look at quality monitoring systems. They identified some areas for improvement such as staff training, supervision, care records and systems for monitoring the environment. From this a quality improvement plan was developed which the management team were working on. Senior staff met with the registered manager and both partners monthly. Minutes showed progress against the improvement plan was monitored, any new issues discussed and actions agreed. This showed the provider was committed to ongoing quality monitoring and to making improvements.

The registered manager explained progress in some areas had not moved as quickly as hoped because of staff changes. However, improvements had been made in standards of cleanliness, in reviewing and updating care records, in staff training and supervision. Audits of care records, cleaning, and medicines were undertaken regularly and actions taken to address any concerns. Other improvements had been introduced such as re-introduction of the maintenance request book and the use of a good practice 'falls pack' to prompt staff further reduce falls risks for individuals. Further improvements planned included updating policies and procedures to reflect the regulatory changes and the introduction of regular staff meetings. The support staff team met regularly and regular care staff meetings were due to commence the following week. This showed staff were being consulted and involved in the changes and improvements being made.

Accident/Incident reports were monitored to identify any trends and identify people at increased risk and showed that actions were taken to reduce risks. Where concerns had been identified about some staff skills or performance, these had been addressed through individual supervision, training and capability procedures in accordance with the provider's policies. This included setting clear expectations of staff and identifying areas where improvement was needed. Individual staff supervision was used to re-enforce the values and behaviours expected of staff, to discuss people's feedback and any lessons learned.

The service had a range of quality monitoring systems in place. These included cleaning schedules, systems for cleaning and checking of equipment such as hoists, hoist slings and wheelchairs. Weekly fire checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. Systems were in place to ensure all electrical, gas and emergency lighting and fire equipment were serviced and tested regularly. Servicing contracts and evidence of recent servicing was seen for the stair lift, lifting equipment, and all utilities.

The provider sought day to day feedback about the service provided and made changes and improvements in response. They also undertook an annual survey to seek feedback. The last survey in 2014 showed very positive findings but did not identify specific areas for improvement. The provider was also considering other tools and suggestions made by the quality monitoring team about alternative ways to monitor and seek feedback from people about their experiences of care

Good

Is the service well-led?

The provider and registered manager kept up to date with changes in practice through contact with local health and social care services. One of the partners was involved in setting up a local memory clinic and had contacts there who had done some staff training. The registered manager was aware of the recent regulatory changes in the Care Quality Commission and used national websites such as Skills for Care and The Alzheimer's Society website to keep up to date with practice changes.

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 How the regulation was not being met: People who use services and others were not fully protected against the risks associated with unsafe or unsuitable premises. Further improvements were needed to ensure health and safety risks were identified, risk assessed, and reduced as much as possible. This is a breach of regulation 12 (1) (2) (a) (b)(c)(d) and (e).