Mr Stephen Castellani

Mont Calm Sandgate Road

Inspection report

211 Sandgate Road
Folkestone
Kent
CT20 2HU
Tel: 01303 251093
Website:

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Ratings

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

Overall summary

The inspection visit was carried out on 24 February 2015 and was unannounced.

The previous inspection was in November 2013. In June 2013 we identified a breach in the regulations in regards to the safety and suitability of the premises. Concerns were referred to the Kent Fire and Rescue Service Fire Safety Officer for their consideration.

Mont Calm Sandgate Road provides accommodation and support for up to 20 older people, including people who are living with dementia and have other complex needs.

The service provider (Mr Stephen Castellani) has been in administration since 23 January 2014. Moorfields Corporate Recovery are the receivers, and they have employed Goldcare Future Management Ltd. to oversee the running of the services. We have referred to these as the 'administrators' in the body of the report.

The premises are a large detached older building, and provide communal rooms and three bedrooms on the ground floor, and bedrooms on the first and second floors. There is a passenger lift to all floors. Some of the bedrooms on the second floor were out of use as a visit

Summary of findings

from the Kent Fire and Rescue Service Fire Safety Officer had confirmed that the external fire escape was unsafe. Action was being taken to remedy this situation. This meant that the home could currently accommodate 15 people, even though the home's registration was for 20. There were 15 people in residence on the day of our inspection.

The external presentation of the building was spoilt by moss covered steps, and cracked and peeling paintwork. Internal décor was satisfactory, but we agreed with a relative who said, "It is a beautiful building, but the paintwork and décor looks very tired". We observed that there were lots of scuffed areas of paintwork. Maintenance records showed that there were many items of repair work to be carried out, and this work was being gradually completed. Health and safety risk assessments had been completed, and had been updated every three months.

The service is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and DoLS. The registered manager had been in contact with the DoLS office, and was in the process of applying for DoLS authorisations for all of the people living in the service, as none had been assessed as safe to leave the building unaccompanied. Urgent applications had already been made.

The service had suitable processes in place to protect people from different types of abuse. All of the staff had been trained in safeguarding people and in the service's whistleblowing policy. (Whistleblowing enables staff to raise matters of concern about other staff in an unbiased way, and without fear of discrimination). Staff were confident that they could raise any matters of concern with the registered manager or with the local authority safeguarding team.

The registered manager had systems in place to record accidents and incidents, and to monitor these to see if there were any patterns of occurrence, such as the same time of day, or the same staff on duty. The registered manager analysed these to assess if any action could be taken to avoid further accidents, and any identified action was taken in response.

Medicines management was overseen by the registered manager, who carried out arrangements for repeat prescriptions and receipt of medicines into the home. Care staff were not permitted to administer medicines until they had completed medicines training and had been assessed for their competency. The medicines storage did not meet regulatory requirements. Controlled drugs (CDs) were stored in a locked cupboard which met requirements, but the cupboard was not fixed with the required 'rag' bolts to a solid wall.

Staff were evident throughout the home during the inspection. Most people chose to spend their day in the lounge and dining rooms which were adjacent to each other on the ground floor. This enabled staff to observe people for any risks, such as unstable walking, or becoming upset with each other. Staffing numbers included three care staff throughout the twenty four hours. The registered manager and deputy manager carried out management and supervision responsibilities.

Staff showed people respect and spoke to them in a friendly manner. Most interaction was evident when staff were assisting people with daily tasks, such as giving them drinks or assisting them to the toilet. There was little interaction apart from this during the morning as staff were busy attending to people's physical care needs, and some people dozed in their armchairs for periods during the morning. An activities co-ordinator spent time with people in small groups during the afternoon, and we saw that people enjoyed her company and were animated in conversations and reminiscence. There was a general lack of items in evidence to stimulate people when the activities person was not on duty, apart from the television, music playing, and magazines. There was no signage or colour coding on doors or walls to assist people with finding their way (for example, to the toilet); but people's bedroom doors had their names on them, and a picture that would help them to find their room.

Summary of findings

The service had reliable staff recruitment procedures in place. Applicants were assessed as suitable for their job roles, and new staff were provided with a detailed induction programme, which included training in essential subjects. Refresher training was provided at regular intervals.

Staff had daily handovers when they were updated with any changes in people's care needs. They confirmed that they had individual supervision every three months, or more often if this was needed. Staff meetings were carried out, and all staff had yearly appraisals. Staff were given training in essential subjects when they commenced employment, and were able to develop their knowledge and skills through further training courses, and formal qualifications.

Staff demonstrated their understanding of the Mental Capacity Act 2005 and how to apply this, by encouraging people to make individual choices about their daily lifestyles, and respecting their decisions. For example, people were given a choice of biscuits and drinks during the morning; and were able to sit where they wanted to.

People showed their enjoyment of the food, by smiling when food was given to them, and saying things such as "This is good" and "I like this". We saw there was little food wasted at lunch time, and portions were a satisfactory size. The menus showed there was a wide variety of food, providing a nutritional diet. Food was attractively presented. People were encouraged to eat together at dining tables, so as to provide social inclusion and the enjoyment of interacting with other people at meal times. Two people needed assistance to eat and drink, and we saw that staff were attentive to them and sensitive to their requests.

People and their relatives were involved in their care planning, depending on the wish of the person receiving care, and their ability to understand the information. Care plans showed that their health needs were assessed, and were monitored accordingly. Records showed that staff contacted people's GPs or other health professionals as needed, and health care was given appropriately.

The registered manager had received one formal complaint in the last year, and records showed that this had been dealt with appropriately and resolved. We received mixed views from relatives about response to concerns. Some said that they had talked to the registered manager but were not satisfied that their concerns had been listened to; while others said they "Could not fault the manager or staff", and that they always responded promptly to any concerns. The registered manager agreed with us that it would be helpful to document smaller concerns as well as any formal complaints, so that the action taken in response could be clearly evidenced.

The registered manager had a daily visible presence in the home and led the staff in caring for people. We observed that people responded to her and showed that they knew her well and felt comfortable in her presence.

Improvements had been commenced in the service since the administrators had been put in charge of the overall management. Audits such as health and safety, and infection control had been carried out, and action had been taken in response to the findings.

Relatives said that they knew the manager had an open door policy and they could ask to speak to her at any time. Relatives' views were sought through the use of twice yearly questionnaires, as well as on a day to day basis. Some relatives contacted the manager through phone calls or e-mails and told us that the manager always answered their questions. A suggestions box and suggestions paper forms were available in the entrance hall. These had been implemented in response to someone's idea, and were used occasionally. The registered manager read these and assessed if any improvements could be made to the home in accordance with any appropriate changes.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Requires Improvement

The service was not consistently safe. Correct procedures had not been followed for the safe storage of controlled drugs.

Staff were trained to understand and apply safeguarding and whistle-blowing procedures, and how to protect people from abuse.

The service had environmental risk assessments in place, and individual risk assessments for each person living in the home. Accidents and incidents were monitored to identify any specific risks, and how to minimise these. Staffing numbers were maintained at a satisfactory level for people's safety and welfare.

Is the service effective?

Good

The service was effective. Staff received on-going training and supervision, and were supported with studying for formal qualifications.

Staff knew how to apply the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and ensured that people were able to take day to day decisions in line with their level of capacity.

The service provided people with a suitable variety of food and drink to enable them to have a nutritious diet. The registered manager and staff were knowledgeable about people's health needs and ensured these were met.

Is the service caring?

Good

The service was caring. Staff treated people with respect and provided a welcoming and friendly atmosphere.

People were encouraged to retain their independence as far as possible, and to follow their own preferences.

Staff responded to people promptly when they required assistance.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. There were not sufficient activities available throughout the day for people living with dementia to enjoy and take part in.

People's care plans were written individually and expressed their personal needs.

Concern and complaints were taken seriously and were appropriately investigated and addressed. They were used as an opportunity to make improvements in the service.

Summary of findings

Is the service well-led?

Good

The service was well-led. The registered manager was effectively supported by a team of administrators.

The registered manager led the staff team and enabled them to take part in making positive changes in the service.

People's views were obtained and were listened to. There were systems of on-going audits to monitor the home's progress.

Mont Calm Sandgate Road

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.

The inspection took place on 24 February 2015 and was unannounced. It was carried out by one inspector.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the provider is required to tell us about by law. We reviewed information sent to us by members of the public who wished to share their views.

During the inspection we carried out an observation for one hour in the morning, called a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff interactions with people and care provision throughout the day.

We viewed all communal areas of the service, and some people's bedrooms. We had conversations with eight people who were living at the service, and met others briefly. We talked with six relatives, and a visiting social worker; and contacted one health professional for their views. We talked with six staff, including care staff, domestic, and activities staff. The registered manager was present throughout the day.

During the inspection visit we reviewed a variety of documents. These included three people's care plans, three staff recruitment files, the staff induction and training programmes, staffing rotas for two weeks, menus, all the medicines administration records, equipment servicing records, environmental risk assessments, quality assurance questionnaires, minutes for staff meetings, auditing records, and some of the home's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said they felt people were safe, and were protected from harm. A family member told us, "I am happy that my relative is here. It is clean and they are well looked after and it is safe." Comments from recent questionnaires included, "The home is warm and very clean"; and, "We like the building, the standard of cleanliness and the level of care".

The administrators and the registered manager had taken steps to keep people safe by carrying out actions required by the Kent Fire and Rescue Service. This had included putting some of the bedrooms on the second floor out of use, as the external fire exit for these rooms was not safe to use. The fire officer had stated that a sprinkler system could be fitted in place of a fire escape, and costings were being carried out for this at the time of the inspection, as well as assessments for a new fire alarm system. An additional member of care staff had been put on duty at night, so that there would be more staff available to help people to move downstairs and out of the building in the event of an emergency. Action had been taken to update the home's fire risk assessment and the evacuation plan. These had been met before the date of the deadline which had been given by the fire officer.

Medicines were stored in a medicines trolley which was kept locked to the wall when not in use, and in a locked cupboard. These were in good order, and clean and tidy. Controlled drugs (CDs) were stored in a locked cupboard which met requirements, but was not locked to a solid wall with the required 'rag' bolts. (CD cupboards should meet British Standard BS2881:1989 security level 1. See Misuse of Drugs Act 1971). The service had a locked drugs fridge for medicines which needed to be stored at lower temperatures, and this temperature was checked and recorded daily. However, the room temperature for the storage of other medicines was not checked or recorded, which meant that the registered manager could not confirm that medicines were being stored at the correct temperatures to prevent deterioration.

The storage concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were administered by staff who had completed medicines training. Records for CDs and for daily administration of other medicines were accurately completed without any gaps in signatures. Each medicines chart was accompanied by a photograph of the person concerned to aid identification. Any known allergies were highlighted. Handwritten entries were checked and signed by two staff to show they had been transcribed correctly from the medicine's label from the dispensing pharmacy. The registered manager carried out monthly audits to check medicines management and administration.

Staff demonstrated a good understanding of different forms of abuse, and how any suspicions of abuse should be reported. They were trained in safeguarding adults, and knew about the service's whistle-blowing policy. This enables staff to raise concerns about other staff without fear of discrimination, if the concerns are raised in good faith. Staff were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so. The registered manager kept a printed copy of local multi-agency safeguarding procedures in her office for staff to refer to if needed.

People's personal monies were stored safely and separate records were maintained. These showed all debits and credits, and receipts of purchase were retained. Records were checked and signed by two senior staff. The records were typed and sent to people's next of kin each month or on request, so that people were protected from financial abuse.

Staff were trained for how to respond in an emergency (such as a fire) to protect people from harm. An emergency folder contained details of what action to take in different types of emergency and contact details. The emergency folder contained a personal evacuation emergency plan ('PEEP') for each person. These identified if people needed one or two staff to assist them, if they could manage stairs unaided, and if they might be at greater risk due to their levels of confusion in an emergency situation. Other emergency precautions included staff being kept up to date with first aid training; having a designated first aider on duty for each shift; and monthly checks for first aid boxes to ensure they were correctly stocked and accessible.

Accidents and incidents were recorded and followed up by the staff, and the reports were reviewed by the registered manager. This enabled her to identify if any patterns were occurring, and if action could be taken to prevent further accidents.

Requires Improvement

Is the service safe?

The service had robust staff recruitment practices, ensuring that staff were suitable to work with the people living in the home. These included checking prospective employees' references, and carrying out Disclosure and Barring Service (DBS) checks before successful recruitment was confirmed. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people). Employment procedures were carried out in accordance with equal opportunities. Interview records were maintained, and applicants were provided with a job description. Successful applicants were provided with the terms and conditions of employment, and a copy of key policies, such as maintaining confidentiality, whistle blowing and health and safety.

Staff told us that most people living in the service chose to sit in the ground floor lounges or dining-room during the day. Three care staff were on duty, and acted promptly when people asked for assistance, or if they saw people becoming restless or upset. Other staff on duty included a cook, two domestic staff, and an administrative staff member. An activities co-ordinator worked for two hours per day, and was on duty during the afternoon. The service employed a maintenance man, who was helping a maintenance person in another of the company's homes, where two maintenance people were needed for the work being done. The registered manager was off duty, but chose to come into the service for the duration of the inspection. The deputy manager was on duty for part of the day to oversee a review meeting of one of the people's care needs.

The building provided a satisfactory environment, but it would benefit from redecoration and refurbishment. There were many areas of scuffed paintwork. A ground floor toilet had a hole in the wall which had been left after the hand wash sink had been moved to another part of the room, and we saw pipe work which needed boxing in. However, the maintenance records showed that the registered manager and maintenance staff had identified these areas of re-painting and repairs, and they were in the process of being dealt with. Other records stated (for example), 'Hot tap drips and does not turn off properly; room needs new net curtains' and 'End of bath panel needs replacing'. This demonstrated that the administrators and the registered manager were gradually bringing about the necessary improvements.

Environmental risk assessments had been carried out in conjunction with quarterly health and safety inspections. These included checking that hot water thermostats were working correctly; checks that window restrictors were in place; reviewing the storage and use of chemicals for cleaning purposes; and ensuring fire drills were up to date. Other repairs needed on a long-term basis were recorded, such as identifying windows which would need replacing in due course.

The premises were seen to be clean internally in all areas, and without any offensive odours except in one bedroom. Staff explained that the carpet was due to be cleaned during the day. Shared toilets and bathrooms included liquid hand wash, paper towels, and pedal bins for waste disposal. Care staff used personal protective equipment such as disposable aprons and gloves when attending to people's personal care. We observed staff washing their hands between different tasks. There were cleaning programmes in place to maintain the cleanliness of people's own rooms, with deep cleaning at regular intervals. The service did not have a sluice facility, and some people had commodes by their beds at night. There was a cleaning system in place for these, using an old bathroom facility which was no longer used as a bathroom for people or staff. There were suitable processes in place for the management of waste and clinical waste.

Good

Is the service effective?

Our findings

People said that they were "Happy" living in the home and "It is comfortable here". Many people were unable to respond clearly to questions due to limitations of their dementia, but were mostly relaxed and smiling, observing others, talking with each other or walking about. Some fell asleep in their armchairs during the morning or afternoon.

People talked to us about the food and said "There's always plenty"; "Yes, I like the food" and "The food is good – I am getting fat!" (This was said with a smile). Lunch time was calm and relaxed, and people sat together at tables in the dining room. Food was served suitably hot and looked appetising. Menus provided a range of foods to enable people to have a nutritious diet. Staff said that they offered people a main menu, according to their knowledge of people's likes and dislikes, and offered alternative items if they knew people did not like the main menu. The main meal was served at lunch time. There was also a hot choice at tea time as well as sandwiches and soups, and desserts offered. People were offered a range of breakfast items, and were given drinks and biscuits in the mornings, and drinks and cakes in the afternoons. We observed that people were given drinks at other times throughout the day when they requested them, or if staff asked them if they would like a drink. Staff told us that snacks and sandwiches were offered with hot drinks at 8pm before people started going to bed.

The kitchen was clean and well organised. There was a wide amount and variety of groceries, fresh food and frozen food available, and catering staff were familiar with people's different dietary needs, such as diabetic diets. Care plans included nutritional assessments, which identified if people were at risk of poor nutrition. People were weighed monthly (or weekly if needed), and staff reported any significant weight loss or weight gains to the registered manager, who then informed other health professionals such as their GP or dietician.

Care staff told us that they had daily handovers between shifts, when they were informed about any changes in people's care needs. Staff training commenced at induction and during the probationary period, when staff were taken through essential training. This included moving and handling, first aid, health and safety, safeguarding adults, food hygiene, fire awareness and infection control. The training programme showed that other relevant subjects were carried out, including dementia training, end of life care, pressure sore prevention, and understanding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards(DoLS). Staff were supported in carrying out formal training, and over half the care staff had carried out National Vocational Qualifications (NVQs) or Diplomas to levels 2 or 3 in health and social care. (NVQs are nationally recognised qualifications which demonstrate staff competence in health and social care). The training programme showed that staff were kept up to date with refresher courses.

All staff had individual supervision every three months, usually with the deputy manager. This included practical assessments such as observing staff carrying out care tasks, as well as individual discussions about their progress and any concerns. Staff had yearly appraisals, which included a self-appraisal, and these were held with the registered manager.

Staff obtained people's verbal consent before they carried out any practical care and asked people where they wanted to go and what they wanted to do, ensuring that they were able to choose. Written consent was obtained from people or their representatives for different aspects of care, such as input to their care plan, and consent to photographs for their identity. Staff had been trained to care for people who might display behaviour that was challenging for other people, and there were guidelines in people's care plans to show how to distract people or reassure them. The staff did not use any restraint practices.

Staff confirmed they had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), and were able to talk about how they supported people who lacked mental capacity. Some people lacked full mental capacity to make complex decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people's choice during the day, for example, offering them a variety of biscuits and drinks, and asking where they wanted to go if they were walking about. However, there were arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. Records showed that people's next of kin or representatives and health or social care professionals were consulted when decisions needed to be taken on behalf of people and in their best interests. During the afternoon a meeting took place with a person's

Good

Is the service effective?

relatives, the deputy manager and a social care professional. This was to discuss what action was appropriate to take for someone who had come into the home as a temporary arrangement, and what was in their best interests.

The registered manager had applied to the DoLS department to obtain authorisation for depriving people of their liberty when going out of the home on their own, as they had been assessed as unsafe to go out of the building unaccompanied. Urgent applications had been sent, and other applications were being prepared. The manager knew how to apply for advocacy services for anyone who lacked someone to represent them.

The staff had sufficient knowledge of people's health needs to ensure these were followed up appropriately. Records showed that other health professionals were contacted for advice or to give treatment as needed. This included professionals such as doctors, matron practitioners, dieticians, dentists, chiropodist, and the community mental health team. On the day of our inspection, one of the people had a dental problem during the morning. The staff team took immediate action to contact a domiciliary dentist, and the dentist visited the person during the afternoon to assess what was needed.

The staff wrote detailed reports in people's care plans, showing the concerns referred to professionals, and the discussions and treatments that were given. These were very thorough records. For example, staff had recognised where a person might have a urinary infection due to higher than usual levels of confusion; had identified where another person had an increased risk of falls; and noticed if people had any new bruises or cuts. These were recorded on body maps, and district nurses were asked to visit if dressings were needed. The registered manager was kept informed about these so as to assess if there was any increase in accidents. A community psychiatric nurse had recently visited to assess someone, and they had noted that the staff had ensured that all their recommendations had been carried out.

Each person had pre-prepared care plan information ready in case of an emergency visit to hospital. This included key details about their communication and their ability to understand and retain information, as well as their medical history, mobility, personal care, dietary needs and usual sleeping pattern. The registered manager told us that the paramedics and hospital staff had said that this information had been helpful.

Good

Is the service caring?

Our findings

People told us "I am quite comfortable and happy living here", and "Yes, it's all ok, they are very good to me". Relatives said "The home is always welcoming, and staff are friendly"; and "You always feel the staff care." Responses from recent questionnaires sent to relatives included, "It is a caring atmosphere, and welcoming"; "We like the staff's good nature, friendliness, and willingness to please"; and "My relative always looks clean and tidy and well cared for".

People were able to sit where they wanted to, and some liked to sit in the same seats every day. Two people told us they had made friends with each other and spent time chatting together. Others were content to watch what was going on, or read magazines or newspapers. Staff responded promptly when people needed assistance, for example, if they wanted a drink or needed help to find the toilet. Staff ensured people's privacy and dignity was maintained, by carrying out personal care discreetly in their own rooms or bathrooms. They knocked on doors and waited for a response before going in, showing their respect for people's private space. Staff recognised people's relatives, and greeted them in a friendly manner and offered them drinks.

People's rooms were personalised with their own possessions according to choice, so that they could have their own things around them. People's bedroom doors had their name and a picture displayed on them, to help orientate people to finding their own rooms.

Relatives gave us mixed reviews about how well staff communicated with them. Some told us that staff always contacted them if they had any concerns about their family members, and this was reflected in questionnaire responses. However, some relatives said that they had to ask for information about their loved ones. The registered manager said that she would follow this up and ensure staff were always proactive in contacting people's next of kin to inform them of any changes or concerns, and check that communication with people's family members was documented. People's care plans showed that discussions took place at the time of admission, to ask if their family members wished to be contacted day or night in the event of any serious illness or accident.

People were encouraged to retain their independence as much as possible, and this was included in their care planning. These showed, for example, if people were able to wash and dress themselves unaided, or if they needed some directions from care staff. Discussions included checking if people could make day to day decisions such as choosing their clothes, if they could manage any personal finances, and if they could open and read their own mail. Each person was allocated with a 'key worker', who held responsibility for keeping people's clothes in good order, ensuring wardrobes and drawers were tidy, checking that people had the toiletries they required, and keeping people's fingernails cut and cleaned.

People were addressed by their chosen name. They were assisted in getting up and going to bed at the times they wished. Care plans included new forms obtained from the Alzheimer's Society called 'This is me', which documented their personal life histories, their hobbies and interests, their family background and their occupational history. These were in the process of being completed, and provided staff with people's personal information in an easy format, so that they could get to know people more quickly, and help them to settle into the life of the home.

Requires Improvement

Is the service responsive?

Our findings

People were asked about their interests and preferences, and group activities were carried out in the mornings or afternoons on alternate weeks. The registered manager told us the staff were trying to "Tailor the activities to people's personal choices". We observed that people did not have much to occupy them during the morning of our inspection and two people said "I have got nothing to do" and "I get bored". Two televisions were on all morning in the lounge areas, but only one person showed any interest in watching one of these. Several people fell asleep in their armchairs during the morning. The lounges included a stack of magazines and some newspapers, but there were no other items in evidence to distract, amuse or stimulate people living with dementia. Two people that we talked with said, "Thank you for chatting with me, I do like it"; and, "Thank you for caring, it is very kind of you to talk to me". However, in the afternoon the activities person spent time with people in small groups, and we saw that people enjoyed talking with her and became animated and joined in the conversations.

People told us that they liked "The music", which referred to the times when entertainers came in to sing with people. A church service was held in the home once per month, and people said they enjoyed joining in with that. A relative told us that someone came in once a week to carry out armchair exercises, and said "He is excellent – everyone loves him!" Other activities included quizzes, reminiscence, drawing and painting, decorating cookies, playing bingo and going out in the garden in good weather. People were able to go out of the home with their relatives, but not usually with staff as this would leave only two care staff on duty for everyone else. People's daily reports included a space to write about their activities, but many of these sections just stated that they had watched television, read books or magazines, or had had visitors. People's bedroom doors had their names and a picture on them, but there was no signage or colour coding on doors or walls to assist people living with dementia to with find their way around, for example, to the toilet.

The registered manager carried out assessments with people in their own homes or hospital before they were admitted. The assessments were thorough, and included detailed information about people to help staff to get to know them quickly. Care plans contained details of people's health and care needs, with individualised plans for all aspects of care, such as their personal hygiene care and dressing, dental hygiene, continence, mobility, mental health needs and dietary needs. Monthly care reviews were carried out by the registered manager or deputy manager, and included checks of all care plans and risk assessments to see if any items needed to be updated. People's relatives were invited to take part in care plan reviews if they wished to do so.

Care plans contained clear details and instructions for staff to follow. For example, one care plan stated, "Is at high risk of falling. Give guidance and reassurance, and remind to use walking stick"; and another stated, "Sometimes has a lie-in after breakfast", and "Has weakness in knees and poor balance, uses Zimmer frame, and needs a bath hoist when bathing". The plans noted when people liked to try and do things for themselves independently, such as washing, dressing or eating, but reminded care staff that one staff should be available to observe and offer gentle help when needed.

The service had a complaints procedure on display which included all the relevant contact details for the service and for Social Services, the Local Government Ombudsman and CQC. People were given a copy of the complaints procedure as part of the welcome pack's statement of purpose and service users' guide. Staff said that people shared any concerns with them and they informed the registered manager. These were followed up and dealt with as quickly as possible. There had been one formal complaint during the previous year, and this had been appropriately investigated and had been resolved. Any concerns were used as an opportunity to assess and improve the overall service provided in the home.

We recommend that the staff follow the guidelines provided by the National Association for Providers of Activities for older people (NAPA); and the National Dementia Strategy for England (in association with Alzheimer's Society), to support the staff in providing an increased range of activities for people living with dementia to enjoy.

Good

Is the service well-led?

Our findings

People and their relatives spoke highly of the registered manager, and said that she was approachable and helpful. A social care professional told us that she had visited the home on many occasions, and the registered manager kept her informed about any changes in people's care needs. She said that she "Popped into the home" as and when it was convenient, and had "No issues" with the running of the home and information provided by staff. Comments from people's relatives included, " I would highly recommend this home to a friend or relatives"; and, "We are pleased with our relative's care and understand the difficulties that their behaviour gives to the staff".

The registered manager said that since the home had been in administration, that the administrators had provided two managers who visited on alternate weeks. One provided oversight in staffing and care; and the other provided oversight in finances and building repair work. The registered manager said that they discussed any current concerns or issues; investigated why things had been done or not done; and had instigated lots of changes. This had provided support to the registered manager and staff through a difficult period. The registered manager said that the administrators were "Very good, and would always be available to discuss and help with any issues or concerns".

The registered manager told us that the staff team were very dedicated, worked well together, and were committed to caring for people. This had been clearly evidenced when the service went into administration before Christmas 2013, and staff wages had been delayed for some months as a result. However, none of the staff had left but had stayed and worked through this crisis time together for the sake of people living at the service. The service was now stabilised, and the staff team were looking forward to a resolution of the current situation.

The registered manager had systems in place to carry out monthly care plan reviews and on-going audits for different aspects of the service. Care plans reviews included checks of people's risk assessments, and these were altered for any changes that were necessary. Audits included a health and safety inspection of the premises, such as checking that the fire alarm and nurse call bell systems were working correctly; and fire exits were clear from obstructions. The registered manager's monthly report included audits for infection control, medicines management, catering, complaints, accidents and incidents, staff training and activities. The registered manager had identified that people would benefit from having more activities, and this had been highlighted as a point of discussion with the administrators, as it may entail more hours being provided for activities staff. She showed us that she had started purchasing more items for activities, in accordance with things that people wanted to do.

The deputy manager carried out individual staff supervision every three months, and the registered manager carried out yearly appraisals. These included checks for any specific staff training needed, to ensure that staff kept up to date with essential training and additional subjects relevant to people's health and welfare. Staff told us that they had staff meetings "Every so often", but received feedback and updated information through daily handovers. The registered manager said that she also sent out letters to staff with the staff wages if there was any subject which was important to share with all staff immediately. Staff said that they could raise any issues themselves at any time, and this enabled them to feel involved in the running of the home. A suggestions box had been placed in the main reception area, and this could be used by staff, people living in the home, or visitors. The registered manager checked this at least weekly, and followed up the ideas or comments that people made.

The registered manager kept her own training and practice up to date. She worked alongside care staff during the week, and arrived in the home early each day so that she could talk with the night staff. There was an emphasis on being a team together over the twenty-four hours, so that day and night staff carried on from each other. The registered manager ensured that CQC were appropriately notified of any untoward events in the home. A notification is information about important events which the provider is required to tell us about by law.

People's views were obtained through listening to their daily comments and observing their moods and body language. Relatives' views were obtained through twice yearly quality assurance questionnaires. These included questions such as, "What do you like about the home?"; "Do you feel that staff treat your relative as an individual?" and "Is their room kept clean and tidy?" We viewed responses from 2014, and saw that these included positive comments such as, "The home is warm and very clean", and "Staff are always pleasant and welcoming".

Good

Is the service well-led?

The registered manager had systems in place which enabled her to locate records quickly. People's personal records were kept in a locked area so as to retain their confidentiality. Records contained appropriate information, had been properly signed and dated where applicable, and were kept up to date.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider had not taken appropriate steps to ensure that there was safe keeping for controlled drugs, in line with guidelines from the Royal Pharmaceutical Society for the Administration of Medicines in Care Homes; and British Standard BS2881:1989 security level 1. (See Misuse of Drugs Act 1971). (Regulation 13).