Kahanah Care

Dene Court 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?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was unannounced and took place on 4 April 2016. The inspection was carried out by two inspectors. The previous inspection of the home was carried out on 10 and 13 November 2015 where we found breaches of regulations. These related to the safe care and treatment, care and welfare of people who use services, assessing and monitoring the quality of service provision, consent to care and treatment, and records. The service was rated as 'inadequate' and placed into special measures.

Dene Court is registered to provide accommodation with personal care for up to 28 older people. At the time of this inspection there were 20 people living there (one person was in hospital). . There was a manager in post who was not yet registered. They have submitted an application for registration and we are currently processing this. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found significant improvements in all aspects of the management of the service since the last inspection. There had been input from the local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT) since the last inspection. These professionals had closely monitored the home and provided training and support to help the provider and management team establish effective care and management systems. We have been kept informed and updated about progress towards achieving the provider's action plan. Staff and people living in the home told us the home was now well-managed.

Improvements had been made in all aspects of safety. While we were satisfied the home was safe and fully compliant in all areas of safety at the time of this inspection we have yet to see that safety standards have been embedded and can be sustained.

Risks to people's health and safety had been assessed, monitored, and there were systems in place to ensure risks were minimised where possible. At the last inspection we found people experienced a high number of falls. During this inspection we found the incidence of falls had decreased significantly. This was due to a number of factors, including improved monitoring of fluid and food intake levels, increased staffing levels which meant staff were able to monitor people's whereabouts more closely, and increased activities and stimulation. Where people had previously experienced anxiety or displayed aggression the staff had worked closely with relevant professionals to find solutions, and we saw examples where this had resulted in positive benefits for people.

New staff had been employed following safe procedures. Staffing levels had increased and this meant there were sufficient staff to meet each person's needs safely. People received care and support from a staff team who had received relevant training and qualifications. Staff had the knowledge and skills needed to enable them to meet each person's mental and physical health needs. Communication systems had improved and

staff were kept well informed about any changes to people's needs through staff meetings and handover sessions between each shift. Staff received supervision regularly in line with the provider's supervision policy. Staff told us they were well supported and there were good systems of communication.

Staff knew how to recognise possible abuse, and the actions they should take. They were confident any suspicions of harm or abuse would be listened to and acted upon appropriately. Staff told us "It's so much better here. We feel we can do a good job and keep people safe and the work is more rewarding."

People's social needs had been assessed and actions had been taken to provide activities and social stimulation for each person according to their interests and preferences. A new activities co-ordinator had been recruited who provided a range of group and individual activities including games, arts and crafts, musical entertainment, and reminiscence. Staff were seen sitting and chatting to people. There was a relaxed and happy atmosphere throughout the home.

Care plans had been improved since the last inspection. Care plans had been re-written and were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. Care plans were very person centred, focussing on what the person could do for themselves, what support they needed day and night, any continence issues and what activities and likes and dislikes they had. Daily records had improved and these showed staff had provided care in line with each person's care plan. Legal authorisation had been sought for those people who lacked capacity to make important decisions for themselves, and who may be deprived of their liberty.

Everyone we spoke with was happy with the food and drinks provided in the home. One person said "The food is lovely. I like it." Another person said "Yes, the food is alright." The kitchen staff knew which people were on special diets such as puree or used thickening for fluids due to being at risk of choking.

Improvements had been made to the storage and administration of medicines. There were safe systems in place to closely monitor medicine administration and these meant medicines were administered safely at all times.

Improvements had been made to the decoration and maintenance of the home. There were plans in place to make further improvements in the future. Maintenance records showed actions were taken promptly to address any repairs necessary. Equipment was regularly maintained and repaired or replaced appropriately. .

New quality monitoring systems had been put in place to ensure the home ran smoothly. However, these had not yet been fully established and therefore we are not yet fully confident that improvements can be sustained on a long term basis. We have rated the outcome areas 'Is the service safe' and 'Is the service well-led' as 'requires improvement'. We will visit the home again within the next 12 months to check that standards of safety and management of the service have been maintained and remain fully compliant.

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 safe although safety systems have not yet been embedded or consistently maintained.

There were enough staff to keep people safe and meet their needs. Risks to people's health, safety and welfare had been assessed, reviewed, and action had been taken to minimise risks where possible.

People received their medicines safely from staff who were competent to carry out the task.

There were processes in place to minimise the risks of abuse to people, for example clear procedures for staff to follow and a robust recruitment and training programme.

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Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs.

People were offered a choice of meals that met their needs and preferences.

Staff monitored people's health and took prompt action when they were unwell

Is the service caring?

Good

The service was caring.

People told us staff were always kind and polite.

People were involved in decisions about their care and treatment.

Staff liaised with other professionals to make sure people were appropriately cared for at the end of their lives.

Is the service responsive?

Good

The service was responsive.

People received care and support which met their individual needs and wishes.

Activities and individual support were available for people who wished to access them. People's daily living choices were respected. .

People knew how to make a complaint and said they would be comfortable to do so.

Is the service well-led?

Requires Improvement

The service was well led.

There was a new manager in post. People told us the new manager was kind and approachable.

People's well-being was monitored and action was taken when concerns were identified.

People were cared for by staff who were well supported by the management structure in the home.

There were systems in place to monitor the quality of the service and seek people's views. However, these had only recently been put in place and therefore we were not fully assured these will be fully effective, or will be maintained for the foreseeable future.

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Dene Court 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. At the last inspection in November 2015 the provider was not meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and the overall quality of the service was rated as 'inadequate' under the Care Act 2014.

At the last inspection in November 2015, there was inadequate safety and leadership which put people at risk. The areas of caring, effectiveness and responsiveness also required improvement. The provider voluntarily agreed to refrain from accepting any further admissions until we were assured that these issues had been addressed. There had been a history of non-compliance and therefore we followed our enforcement procedures to ensure actions were taken to improve the service. The service was part of the local safeguarding process and supported by the council quality assurance and improvement team. As part of our enforcement process the service provided us with a satisfactory action plan and representations to show us why they felt they had addressed the issues we raised. Therefore we carried out this inspection to check whether sufficient improvements had been made since November 2015 to ensure that people were safe and their needs were being met.

This inspection took place on 4 April 2016. This was an unannounced inspection which meant the provider, registered manager and staff did not know we would be visiting. It was carried out by two inspectors. We reviewed the previous inspection reports before the inspection. We also reviewed the information we held about the home. This included safeguarding and quality assurance reports and feedback from Devon County Council commissioners and community health professionals. Feedback was positive showing that they felt improvements had been made. There had been no new safeguarding alerts since the last inspection. The safeguarding process was closed following a meeting in February 2016 where significant improvements were found.

At the time of this inspection there were 20 people living at the home (one person was in hospital). The

home is registered for up to 28 people. During the day we spoke with ten people who lived at the home, one relative who was visiting and two health and social care professionals. Most of the people we spoke with, however, were unable to comment on their experiences directly due to living with dementia. Therefore, we spent time observing care provided in the communal areas and staff interactions with people. We also spoke with six members of staff, the new manager, deputy manager and the provider. We looked at a sample of records relating to the running of the home and to the care of individuals. This included six care plans, food and fluid monitoring charts, risk assessments, medication administration records (MARS), three staff personnel files and the service improvement plan (SIP). We toured the premises, all accommodation and communal areas and the kitchen. We also looked at medicine storage and administration.

We were assured that significant improvements had been made across the service. However, we have yet to be satisfied that compliance can be sustained in the future therefore we have rated the service as 'requires improvement'.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the service was not safe. There were insufficient staff to meet people's needs safely, medicines were not stored or administered safely, and risks to people's health, welfare and safety had not been fully assessed, reviewed, or actions taken to minimise the risks where possible. During this inspection we found significant improvements had been made to address all of the previous breaches of compliance and the service was safe. People told us they felt safe living at the home and with the staff who supported them. While we were satisfied the home was safe and fully compliant in all areas of safety at the time of this inspection we have yet to see that safety standards have been embedded and can be sustained.

The provider now had systems in place to make sure people were protected from abuse and avoidable harm. For example, staff told us they had received training in safeguarding adults and training records confirmed this. Staff had a good understanding of what may constitute abuse and how to report it. There had been no new safeguarding alerts since the last inspection in November 2015. All staff were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. One member of staff said "It's so much better here. We feel we can do a good job and keep people safe and the work is more rewarding."

One relative said they had seen a marked difference in how their relative was cared for. They had had a medication review and their mental health had improved. The person told us they enjoyed the time staff spent with them and the increased activities. They also told us how they liked the changes to the communal spaces which enabled them to use the quieter lounge with another person they enjoyed spending time with. The relative felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any and they felt they would be listened to and action would be taken to address any issues raised.

Staff encouraged and supported people to maintain their independence. There was a good balance between promoting independence and managing risk. There were risk assessments in place which identified risks and the control measures in place to minimise risk. For example, where people were at risk of falls there were clear instructions for staff about how to minimise the risk of falling. Care plans contained individual records of any falls and what action had been taken. There had been few falls since the previous inspection. Some people were living with dementia and liked to remain independently mobile. Staff were vigilant to ensure they were safe. For example, staff noticed when one person had their shoes on the wrong feet and discreetly helped them to change their shoes. One person who was usually independently mobile had slipped on some stairs. The care plan showed how staff had discussed moving them to a ground floor room and ensuring they had new slippers to minimise further risk of falls. This person was therefore still able to choose where to move around the home but risks were minimised. We saw that individual risks to people had been discussed with them wherever possible.

The overall dependency levels of the people living in the home were lower than the dependency of people during the last inspection and there were eight vacancies. The combined effect of lower overall dependency levels along with higher staffing levels had resulted in staff being able to meet people's needs fully. Four

people were monitored as to their whereabouts to ensure they remained safe. This had been poorly managed during the last inspection, where there was no formal system to safely monitor mobile people at risk of falls, for example. This was now managed using 24 hour monitoring charts. These were completed in 30 minute checks and we saw staff physically checking how these people were, whilst promoting their independence. One person walked very slowly with their frame and required support. We saw this person being able to move around the home as they wished supported by kind, patient staff who chatted as they walked with them. However, we were unable to assess that this would be consistently sustained at present or when the home was fully occupied or provided care for people with higher, complex needs.

Another person was at risk of displaying behaviour which could be challenging for staff. The risk assessment showed comprehensive detail about how to minimise this risk, including the person's background, triggers, preferences and likely behaviour. There were clear instructions about how to minimise risk of harm including who the person liked to interact with and how to diffuse challenging situations. This person was calm and appeared happy throughout the day with staff giving them clear explanations about what they were doing. One person could be verbally challenging and this had been well managed including referrals to relevant health professionals.

Monthly Waterlow risk assessments had been completed. Waterlow risk assessments are a nationally recognised tool to assess the risk of skin pressure area damage. Previously these risks had not been well managed. During this inspection, we saw risk assessments relating to tissue viability were completed, up to date and regularly reviewed. When a high risk was identified there was a related care plan to show what actions staff should take to minimise this risk. For example, people had pressure relieving cushions where appropriate and two people had specialist electric air mattresses. These were checked regularly to ensure they were at the correct setting which was displayed in the person's room. No-one at the home had any pressure sores or was being nursed in bed. Recent records showed how one person had had their position changed regularly in bed at the end of their life to prevent pressure sores and staff had recorded the state of their skin each time taking appropriate action.

At the last inspection we found that when people had been identified as being at risk of malnutrition and/or dehydration this had been poorly managed putting people at high risk despite input from health professionals. At this inspection this area had been fully addressed. Six people had been assessed as being at high risk. These people were monitored by staff using new food and fluid charts. The charts enabled staff to record any food or fluid offered at any time throughout the day and night. The manager said they also encouraged and reminded staff that food and drink could also be offered during the night and was available. Records showed all four people were receiving regular and nutritious meals including high calorie milkshakes. One care worker sat with one person in their room encouraging them to drink their milkshake and made them more toast as it had gone cold. Daily food and fluid input was totalled up by staff after lunch and again at the end of the day to ensure people were receiving optimum levels of nutrition and hydration. Finger food and snacks were given, especially to those people living with dementia who preferred to walk around. Care plans showed people were weighed regularly and any changes noted and action taken.

Previously there had not been enough staff to meet people's needs, which put people at risk. Since the last inspection new staff had been recruited. Staffing numbers had been increased appropriately and staffing numbers were consistent across the shifts with additional staff employed from external agencies to cover any shortfalls. The home now used a dependency tool which enabled them to provide sufficient skilled and experienced staff to meet people's needs. The provider was at the home most days and a new manager had been employed.

On the day of our inspection there was a manager, a deputy manager, one senior care assistant, three care

assistants, a cook, a cleaner, a kitchen assistant, a laundry assistant and an activities co-ordinator on duty providing care and services for 20 people. The provider was also present. Staff told us the new staffing levels were constantly maintained and we saw that agency staff were employed on the day of our inspection to fill gaps in shifts where necessary. The new manager told us the use of agency staff was decreasing as new permanent staff were employed.

Staff told us the increase in staffing levels had made a positive improvement to the care people received. They no longer felt rushed, and they felt they were able to focus on individual needs. The deputy manager said, "Higher staffing levels have made a huge difference. The focus is hugely on the residents and the staff are more involved and can have their say." Another member of staff said "People come first now."

The provider said that as new admissions were accepted over time to fill the eight vacancies, staffing levels would be reviewed as needed and determined by the dependency tool. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life.

People during this inspection received care and support in a timely manner. Particular records showed how staff had been very attentive and provided good care for one person recently at the end of their life. Staff now had time to sit with people, chatting, reassuring people who were anxious and taking part in activities. One care worker, for example, noticed that a person seemed a bit 'down'. They sat with them saying, "Would you like a cup of tea and talk about it?" The person then chatted with the care worker looking at the fish in the fish tank together and appeared visibly calmer.

A new activities co-ordinator had also been employed for 16 hours a week and staff were encouraged to be involved in activities which had not previously been the case. One person said "Yes, there are enough staff. They always pop in to see me as I like to stay in the quieter lounge. I don't have to wait long to see staff if I need assistance." We saw staff checked on people who were in their own rooms during our inspection.

The communal areas had been re-configured which encouraged and stimulated people to socialise and move freely throughout the home safely. For example, there had previously been two main lounge/dining areas and one small lounge area. This had been changed to create one main lounge and one dining room, with the small lounge area remaining the same. The new dining room was a pleasant, large, airy eating space with room for everyone. The room was also used for activities. People could choose to use the middle television lounge or the large quieter lounge across the patio area. This also had a TV area. This created spaces where people living with dementia were stimulated and wanted to be. It also meant that staff were no longer split between two dining areas at mealtimes. Staff were now able to remain in the dining room at mealtimes to offer assistance when necessary. They were also on hand to monitor people who may be at risk of choking.

At the last inspection in November 2015, some aspects of the home's premises and level of maintenance did not ensure people were safe, especially those people living with dementia who were independently mobile. This area had been fully addressed to ensure people were safe. For example, all windows now had window restrictors, fire doors guards were in working order and used appropriately and hazards such as electric wires and unfinished maintenance work had been resolved. The home is an older style building which meant there were continual maintenance needs. There was a maintenance plan of on-going work as some areas needed refreshing but overall the premises were safe for people to access. We discussed one area where the stairs were narrow and steep although a stair lift was in place. The manager had a map of the home and was recording where falls took place to assess whether there were any recurring patterns. They said they would risk assess individuals, particularly those living with dementia who may access these stairs independently and put relevant measures in place.

The home was clean and well maintained. There were no lingering offensive odours and staff ensured that toilets and bathrooms in particular were kept clean throughout the day. There were plenty of aprons, gloves, hand gel and liquid soap available and staff were wearing appropriate personal protective equipment (PPE) to minimise the risk of infection. The laundry room was clean and tidy. Laundry equipment was in good working order. There was a separate laundry basket for each person to minimise the risk of personal laundry becoming lost or returned to the wrong person.

The medicines had not been well managed at the last inspection. At this inspection we looked at the way medicines were managed at the home and found systems had been improved and were being closely monitored. There was a secure room for medicine storage including medicines that required additional security. Medicines were supplied in bottles and packets every four weeks from a local pharmacy. At the last inspection we found unexplained gaps in the medicine administration records (MAR) and inadequate checks and audits to investigate unexplained gaps. At this inspection we found no unexplained gaps. The administration records were being checked at the end of every staff shift to make certain that medicines had been correctly administered and recorded. Regular audits were being carried out to check stock levels against the records of medicines administered. This meant any errors were quickly identified and rectified. We checked the stock level of medicines for two people and found the recorded stock levels were correct.

Medicines were administered by staff who had received training in the safe administration of medicines and who had been assessed as competent. We saw a member staff wearing a red tabard with the words 'Do not disturb' written clearly across it to minimise the possibility of being interrupted while administering medicines. This showed that staff understood that safe medicine administration was a priority during medicine rounds. Creams and lotions were recorded each time they were administered. There were no unexplained gaps. Staff were given good information about how and when to administer the creams, including body maps.

Medicines that should be stored at a cool temperature were kept in a locked refrigerator. The temperatures were checked daily to ensure they were stored at the correct temperature at all times. Insulin was stored for one person who was diabetic. The insulin was administered only by named staff who had been specifically trained by specialist community nurses to carry out the procedure.

Medicines were checked when received into the home to ensure they were correct. Any missing medicines were chased up to ensure new stocks were received before old stocks ran out. Unused medicines were returned appropriately to the pharmacy. The deputy manager told us they had recently experienced some problems with supplies which they were in the process of addressing with the pharmacy.

We looked at three staff personnel and recruitment files. Risks of abuse to people due to unsuitable staff were minimised because the provider made sure prospective new staff were checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers, photo identification and checking that job applicants were safe to work with vulnerable adults. For example, disclosure and barring checks (DBS) on criminal records were completed prior to new staff commencing employment.

There were good personal emergency evacuation plans (PEEP) for each individual. These gave good information as to what people's risks were and how to manage and support them in an emergency such as a fire. For example, whether staff needed to prompt people to evacuate and show them where to go.
We have rated the safety of the home as 'requires improvement' as the service has not yet been able to demonstrate that safe standards can be sustained.

We recommend that you explore national guidance from HSE on Reducing the risk of falls on stairs - www.hse.gov.uk/healthservices/slips/reducing-risks-stairs.htm

Good

Is the service effective?

Our findings

At the last inspection we found the service was not fully effective because staff were not supervised in line with the provider's supervision policy. We also found the service had failed to assess people's capacity to make decisions about day to day issues. At this inspection we found these issues had been addressed.

The staff all had a good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. People who were able spoke highly of the staff who worked in the home. One person said "Oh yes, it's ok here. The staff will do what you need them to do. The manager went and bought me some art materials so that made me feel good."

New staff completed a clear induction programme which was recorded. Competencies were signed off before staff were able to work unsupervised. The manager said they used resources from a nationally recognised training programme.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. There was a programme to make sure staff training was kept up to date. The manager was keen to invite external professionals to run additional training sessions for staff. One had been run on the Mental Capacity Act 2005 and the Deprivation Of Liberty Safeguards, end of life care, falls prevention and nutrition. This ensured staff had up to date knowledge of current good practice and were putting their learning into practice.

Staff received supervision on an individual basis from the manager, deputy manager and senior care workers. Records showed these were now in place or booked. Staff told us they received supervisions and they could always seek advice or supervision whenever they required. Staff one to one supervision records were comprehensive and showed that staff were able to discuss various topics such as learning needs, health and wellbeing and work/ life balance. One care worker had commented, "[Staff member name] is excellent and really helped me through my induction. I have learnt a great deal and all staff are 'real carers'." Staff meetings were held regularly and these were an opportunity for staff to speak up and raise any issues or concerns, which meeting minutes confirmed.

People had access to health care professionals to meet their specific needs. During the inspection we looked at four people's care records. These showed people had access to appropriate professionals such as GPs, dentists, physiotherapists, district nurses and speech and language therapists. For example, people were referred to the falls prevention team as appropriate and there had been input from occupational therapists. Many of the people living at the home had had medication reviews after being referred to their GP. This had resulted in people's mental health and incidence of behaviour which could be challenging for staff decreasing and an improvement in people's quality of life. Two people in particular were now able to enjoy activities and visits out with their family. People said staff made sure they saw the relevant professional if they were unwell. Care plans recorded when families had been informed of any changes.

A Community Psychiatric Nurse (CPN) was visiting the home during our inspection. Their input had been requested for a person who had previously experienced high levels of anxiety. They had recommended a change of medication and this had been agreed by the person's GP. This had resulted in significant improvement in the person's well-being. The CPN told us this was an excellent piece of joint working between professionals and the staff. They praised the staff team for the care they had provided.

Most people who lived in the home were not able to choose what care or treatment they received. The manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Throughout the day staff demonstrated that they were familiar with people's likes and dislikes and provided support according to individual wishes. Each care plan contained detailed information about people's level of understanding, who their next of kin was and whether they had a legal power of attorney to be able to make decisions on a person's behalf. Plans also included whether people could choose their own clothes, how they liked to be monitored at night, whether they liked the light on or off and how to manage any difficulties people had. One care plan stated that a person communicated well with people who smiled and that they sometimes forgot their words so needed time to communicate. We saw staff following the care plans.

Where people were given medicines covertly this had been discussed following a 'best interest' procedure. The person's capacity to make decisions about their medication had been considered. The decision to administer medicines had been reached only after considering all possible options

One person required some restrictions to be in place to keep them safe. The manager had made appropriate applications to the local authority to deprive this person of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the person's advocate to enable staff to use equipment that kept the person safe using the least restrictive method. Staff were aware of the implications for this person's care. The provider kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted.

Everyone we spoke with was happy with the food and drinks provided in the home. One person said "The food is lovely. I like it." Another person said "Yes, the food is alright." The kitchen staff knew which people were on special diets such as puree or used thickening for fluids due to being at risk of choking. Some people required assistance with eating and drinking and staff sat with them at eye level discreetly prompting and supporting them.

We observed the lunchtime meal being served in the dining room. People sat at tables which were nicely laid and each had condiments for people to use. We saw that throughout lunch people were treated with respect and dignity. They were not rushed. There was friendly banter between people. This helped to make lunchtime a pleasant, sociable event. People were able to choose where they wanted to eat, and this meant some people were able to eat their meals in their rooms if they wished.

The home was now well maintained and provided a pleasant and homely environment for people. People who lived in the home were involved in choosing colour schemes and furnishings and their rooms were all

personalised and homely. Two care workers were discussing how to display one person's art work in their room. Work was also on-going to make the environment more dementia friendly. This included clear pictorial signs on toilets and bathrooms and these doors were in the process of all being painted a bright colour to further assist people living with dementia to independently access bathrooms. This was a recommendation from the last inspection.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There were stair lifts to assist people with all levels of mobility to access all areas of the home and people had individual walking aids, wheelchairs or adapted seating to support their mobility. There were wheelchairs and hoists with individual slings for people. All equipment had been serviced regularly. One person had had their mobility scooter delivered and the manager had ordered new batteries. The person said they were looking forward to going out on it soon.

Good

Is the service caring?

Our findings

At the last inspection we found the service was not always caring. We found that people at the end of their lives could not be certain they would receive care that ensured their death was peaceful and dignified and met their expressed wishes. We also found that while staff supported people in a caring and respectful manner they did not always have time to spend with people. At this inspection we found significant improvements. Staff had time to sit and talk to people, and to support them in a caring and unhurried manner. They also had good information about people's wishes for their care at the end of their lives.

People were supported by kind and caring staff. Staff talked with us about individuals in the home. They had good knowledge of each person and spoke about people in a compassionate, caring way. People who were able to tell us directly about their experiences seemed calm and happy, interacting with staff who showed a good rapport with people. One person said "They are nice people, I'm fine here." One relative was very happy with their relative's improvement and said they were happy with all the staff.

Throughout the day we saw staff interacting with people who lived at the home in a caring and professional way. One care worker said "Staff really care about the people here unlike other places I've worked. There are no problems. I love it here." Agency staff we spoke with said they enjoyed working in the home and commented "It's all really lovely. It's like coming into a family." They talked about the importance of treating people with respect and understanding.

We saw that some people used communal areas of the home and others chose to spend time in their own rooms. People had a call bell to alert staff if they required any assistance. They told us these were answered reasonably quickly and we saw they were during our inspection. We saw that staff respected people's privacy and maintained their dignity. For example, staff always knocked on bedroom doors and waited for a response before entering and checked on people in their rooms if they were unable to use the call bell. We saw that bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. One care worker noticed a person had their skirt all tucked up and helped them change their clothes when they were dirty after lunch. Staff were also attentive to people's body language. For example, they noticed when one person appeared tired and assisted them for a lie down. This was clear in their care plan and showed staff regularly assisted the person to bed when they seemed tired but were unable to communicate this verbally.

Staff supported people who were distressed in a sensitive and discreet way. Records showed how two people with mental health needs spent a lot of time together. Staff now monitored how they were interacting and spent time reassuring one person that the other person was ok and not to worry. Where people living with dementia liked to walk around the home throughout the day, staff monitored how they were doing and acknowledged them as they moved around the home. Staff offered tea and coffee to encourage people to rest and guided people to activities that may hold their focus for a while.

People were able to make choices about their day to day lives. Care plans were very detailed about people's life history and preferences and likes and dislikes. Staff were able to tell us about what people liked. For

example, one person who liked gardening had been able to go outside and participate. Another person who could become anxious liked to be kept busy as they felt like an 'employee'. Staff offered the person chores such as laying the table or wiping the table down. People said they chose what time they got up, when they went to bed and how they spent their day. Some people liked a lie down in the afternoon and another person liked to do their hobby in their room, which was happening. One person said "You choose what you want to do here. I like to stay in the quiet area and that's ok with them." People were able to choose whether to join in with activities and there was the option of one to one time with the activity co-ordinator doing things they liked to do. Care plans now identified where people had mental health issues and how to effectively manage them in a caring way. Daily records then referred to how people were feeling, whether they required more assistance or reassurance than usual and referrals to health professionals were made appropriately.

The relative we spoke with told us they were always made welcome and were able to visit at any time. They arranged when they were taking their relative out and that person told us how they were going to ask staff to help them pick out an outfit for the occasion. They said, "They are so kind and helpful. If I want something done they just do it." People were able to see their visitors in communal areas or in their own room. Records noted when people had seen their families, some entries showing visits later in the evening. Records also clearly stated when people did not want to see a particular person. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality.

Care records now contained detailed information about the way people would like to be cared for at the end of their lives. This was on-going and appropriate family were involved. One care plan for a person who had recently passed away showed how staff had been very attentive, providing mouth care, regularly relieving pressure to minimise risk of sores and monitoring the person's condition providing appropriate pain relief with input from health professionals. There was information which showed the appropriate discussions and capacity assessments had been had about whether people wished to be resuscitated. Staff were aware of those decisions. Appropriate health care professionals and family representatives had been involved in these discussions. Staff were receiving training on end of life care and put their learning into practice.

Staff spoke with fondness about people who had recently died and talked about how they had spent time with people in the last days of their life. They told us the care plans and recording systems for people at the end of their lives were very good and gave them all the information they needed, for example if they needed to be checked every 15 minutes.

Good

Is the service responsive?

Our findings

At the last inspection we found the service was not fully responsive. Care plans did not always give sufficient or up to date information about each person's needs. People's social needs were not met. There was no programme of regular activities in the home. At this inspection we found improvements had been made and all breaches of regulations had been addressed.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone and used the dependency tool to ensure there were enough staff to meet people's needs. People were involved in discussing their needs and wishes; people's relatives also contributed, for example in completing life histories. These were very informative and used by staff as working documents. One person did not like particular types of people due to past experiences and staff were aware and met their needs accordingly. We were assured that any new admissions would be carefully assessed to ensure their needs could be met.

During the inspection we read four people's care records. Staff were aware of people's care plans and risk assessments and provided care in line with these assessments. Care plans had been re-written and were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. Care plans were person centred, focussing on what the person could do for themselves, what support they needed day and night, any continence issues and what activities and likes and dislikes they had.

People told us they were involved in planning and reviewing their care if they were able. Some people did not want to be involved. We saw people's care plans were discussed with them each month and changes were made if necessary. Reviews were meaningful and care plans changed to reflect care. We discussed how the staff could record acute, temporary changes to make them clearer for staff such as a wound, sore skin or temporary illness. At present some of these issues were recorded in the daily notes which could be 'lost' within the care plan. We did see, however, that appropriate actions were being taken and body maps were used to monitor any issues.

Handover was comprehensive between shifts to ensure staff were up to date with people's care needs. Staff used a daily diary and handover sheets. A recent staff meeting had raised that the activity co-ordinator should be included in handover and this was being put in place. People had signed some of their care records and the record of each monthly review. Where people lacked the capacity to make a decision for themselves staff involved other professionals and family members in writing and reviewing plans of care.

Staff at the home responded to people's changing needs. Daily records were now more detailed and

showed staff understood people's care needs and reflected this in their comments. For example, they detailed how people had been feeling, how any behaviour challenging to staff had been resolved and what choices people had made. One record stated how a care worker had asked if the person wanted to get up at 8.30am, which they didn't, so they went back an hour later to help them. This showed that choice was continuously offered and flexible depending on the individual.

The service had not previously had an employed activities co-ordinator and there had been a lack of stimulation and engagement with people as staff had been too busy. During this inspection there was a new activity co-ordinator who was employed for 16 hours per week. This had clearly made a big difference to the atmosphere at the home. We saw care staff engaging with people and being involved in activities. The activity programme was displayed and included quizzes, dancing, exercises, films, art and baking. Some people had made cakes with assistance. During the inspection some people were watching a film they had chosen and others were attending an art session. Records had been completed following each group activity showing the people who had participated and if they had enjoyed the activity. Two people we spoke with said a variety of activities were provided, telling us how they particularly liked the soft ball game. Another person said they were supported to pursue their hobby and the manager was arranging for them to visit town to purchase equipment. People could choose to take part if they wished. We also saw the activity co-ordinator sitting with individuals chatting, and reading newspaper articles with them.

External entertainers were also booked such as music and health sessions. The provider had introduced a 'Weekly Sparkle', a topical newsletter to promote engagement and chat. There were magazines and newspapers being read by people. A reminiscence box of vintage toys and articles was available and one person told us how they enjoyed looking at those. Dementia 'Twizzlers' had been introduced. These are sensory material muffs which people living with dementia could use to stimulate them.

The new manager told us questionnaires had been given to people living in the home and their relatives, although they were unable to find the response to the most recent questionnaires for 2015. They told us new questionnaires had been given to people living in the home and their relatives and visitors and they were awaiting responses.

People who could respond effectively said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. The relative had no concerns and felt they could speak with the manager or staff. There had not been any formal complaints since the last inspection. There was a complaints policy in place.

Requires Improvement

Is the service well-led?

Our findings

We found significant improvements in the management of the service since the last inspection. People told us the home was now well-managed. Comments included "Yes, I am very happy here" and "Yes, it's alright." Staff spoke positively about the improvement in the management of the home, for example, "It's so much better now."

At the time of the last inspection there was a registered manager in post who also managed another service run by the provider which is situated in Exmouth. The registered manager resigned their post as manager of Dene Court and returned to manage the home in Exmouth on a full time basis. A new manager has been recruited on a full–time basis for Dene Court, who started employment in February 2016. They have submitted an application to register as the manager and we are currently processing their application.

Daily routines in the home had been improved by improving communication systems. Handover sessions at the end of each shift were clearly recorded and there were checklists in place to make sure all records such at medicine administration records, food and fluid intake records, and monitoring checks had been completed and recorded. Staff meeting were held regularly to ensure staff were kept updated, for example of any changes in routines or procedures. The level of training for all staff had increased.

The provider and management team had also attended training sessions and conferences to increase their knowledge and awareness of current good practice and legislation. The provider had attended dementia training recently and had also attended meetings and conferences with the local authority and other care providers in which they received regular updates on new legislations and good practice. The manager had recently attended training on falls prevention, nutrition and hydration. They had also attended a conference for managers and care providers.

Health and social care professionals told us they had seen improvements in the management of the home in recent months. Since the last inspection there had been a great deal of input from the local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT). They had closely monitored the home and also provided training and support to help the provider and management team establish effective systems. We had been kept informed and updated about progress towards achieving the provider's action plan. The provider told us they had welcomed this input and felt they had been on a "massive learning curve." They could see the improvements that had been made and the benefits to people living at Dene Court. They also recognised they had more work to do, saying "We are not there yet, but we are getting there."

Before the inspection we spoke with professionals in the local authority commissioning and QAIT teams. They told us they had seen improvements in all areas of the home, including the management structure, care plans, and staffing. They had seen a reduction in the use of agency staff and staff roles and responsibilities being made much clearer. The introduction of an assessment tool to assist with determining the numbers of staff based on the service user's needs had been effective. They told us, "When visiting Dene Court the atmosphere feels calm and the care staff are engaging well with the service users."

Where professionals had made recommendations for improvements the provider and management team had acted upon their recommendations. The provider had accepted advice and guidance from the QAIT team to establish a detailed quality assurance system throughout all areas of the home, including care plan audits, medication audits, and routine health and safety checks and audits. The provider showed us the most recent copy of their quality monitoring and improvement plan (they referred to this as the Service Improvement Plan or SIP). The provider met with the management team on a weekly basis to review their progress towards this improvement plan and agree any actions needed. For example, where people had suffered a fall staff had made referrals to a specialist team of health professionals. The service improvement plan showed the referrals had been chased up where the response was slow.

The provider gave us a copy of their service improvement plan. This showed the provider had monitored many aspects of the service and where actions were necessary the plan showed the name of the person responsible for completing the action, and when they expected it to be completed. There was a 'traffic light' colour coding system in place to show actions completed, in progress, or required.

There were some aspects of the service that had not been included in the service user plan. For example, there was no evidence to show how people living in the home had been involved or consulted about the service. We were unable to see evidence to show that people had been encouraged to make suggestions or comments, for example through questionnaires or resident's meetings. The new manager told us they had sent questionnaires out to relatives a few months ago but they were unable to find any responses. They told us they were about to send out more questionnaires and would consider other ways of consulting with people, for example by establishing regular resident's meetings. A register of complaints was held in the home and the manager told us they had received no complaints since the last inspection. Complaints had not been included in the service improvement plan. We discussed this with the provider and manager and they assured us they would review their service improvement plan and include service user involvement in future plans.

Where people had suffered accidents such as falls these were reviewed by the manager every month to look at trends and to consider if any further actions could be taken to reduce the risk of further accidents. However, the reviews had not been recorded and therefore there was no evidence to show the outcome of the reviews. We discussed this with the provider and manager and they immediately addressed this by including in their service improvement plan with evidence of actions to minimise recurrence, for example by improving the handrails on staircases.

There was a maintenance plan in place for the home. All routine maintenance had been planned and recorded when completed. Equipment such as hoists had been regularly serviced and maintained. A new hoist had recently been purchased to replace an old hoist. There was a plan in place showing future improvements to the home such as redecoration of bedrooms, redecoration of the outside of the house, and redesigning and improving the garden areas. The plan showed the expected dates for completion. Risk assessments had been carried out and were regularly reviewed on all areas of the home, grounds, and equipment. We saw evidence of actions taken to address issues where necessary, for example a problem with hot water supply to some parts of the home during March 2016 had been resolved.

Although our findings have shown that significant improvements have been made since the last inspection in all aspects of the management of the home, systems to monitor the quality of the service had only recently been put in place and were not yet fully established. There were some areas not covered by the quality monitoring systems, although we were given assurances these were addressed immediately. We are not yet fully confident that the provider and management of the service will in future be pro-active and will be able identify issues and areas that need to be improved and will take actions to address these promptly.

We therefore need to see sustained improvements to their quality monitoring systems, and the system needs to be embedded.