Alpha Care Caterham

Coombe Dingle Nursing Home

Inspection report

14 Queens Park Road, Caterham CR3 5RB
Tel: 01883 345993
Website: www.coombedinglenursinghome.co.uk

Date of inspection visit: 16 January 2015
Date of publication: 19/03/2015

Ratings

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

Overall summary

Coombe Dingle Nursing Home provides nursing, personal care and accommodation for up to 42 older people, some who are living with dementia. Others have an acquired brain injury or who have behaviour which may cause them to harm themselves or others. The home is over three floors, has a lift for easy access for people. There is a dining and two lounge areas on the ground floor, together with an activities room and a level garden to the rear of the building. On the day of our inspection 34 people were living in the home.

This inspection took place on 16 January 2015 and was unannounced.

The home is run by a registered manager, who was present on the day of the inspection. 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.

Summary of findings

People told us they felt safe and staff had written information about risks to people and how to manage these. People were supported to take risks within a controlled environment. For example, using the stairs rather than the lift when they wished. However, staff used incorrect manual handling procedures when they supported people to get out of their chairs, which placed the person and staff at risk of injury.

Medicines were not managed effectively and staff did not follow correct and appropriate procedures in relation to medicines.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. Information was available to people as well as their relatives.

Care was provided to people by staff who were trained to carry out their role. Some people said they would like to see more staff on duty and, particularly in the morning, staff were rushed. However, people did not have to wait to be assisted. One person said, "When I call for help they (staff) come." Staff were provided with specific knowledge to provide effective care. For example, staff had undertaken training in dementia, challenging behaviour and end of life.

The registered manager explained their understanding of their responsibilities and processes of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). There was currently no one living at the service who was restricted in any way. The registered manager explained they were in the process of ensuring mental capacity assessments were in place for people where appropriate. For example, in the event a person had bed rails.

People were provided with freshly cooked meals and facilities were available for staff to make or offer people snacks at any time during the day or night. People felt the food was good.

Staff ensured people had access to healthcare professionals when needed. For example, the doctor or optician. The GP visited the home each week and met with people.

Staff had developed relationships with people. However, people were not always provided with the dignity and respect they should expect.

Care plans were individualised and contained information to guide staff on how someone wished to be cared for. Care plans were reviewed regularly however we found some care plans did not contain individualised information about the person such as their likes/dislikes, interests or wishes in relation to activities. People had personalised care responsive to their needs. For example, one person had one to one care from staff. We heard of the ways in which staff supported and enabled people to maintain their independence and take part in various activities to reduce the risk of social isolation.

Complaint procedures were accessible to people. We read the provider had responded to complaints in a timely manner.

The provider asked relatives for their views on the service and used the feedback to develop an action plan of improvements. The provider was working with a trained healthcare professional to improve the environment and make it more appropriate for people who were living with dementia.

The registered manager was involved in the day to day running of the home. This was supported by our observations and staff comments. One staff member told us, "The (registered) manager is always around." However, we felt the amount of time they spent out on the floor may have had an impact on their managerial duties and responsibilities.

We saw evidence of regular quality assurance checks carried out by staff to help ensure the environment was a safe place for people to live.

During the inspection we found some breaches 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Staff did not follow good medicines management procedures.

Staff did not use safe manual handling procedures to move people.

There were enough staff on duty to meet the needs of the people, although staff were rushed in the morning.

Appropriate checks were undertaken to help ensure suitable staff worked at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff had a good understanding of DoLS and the Mental Capacity Act, not everyone had received a mental capacity assessment when needed.

Staff were trained and supported to deliver care effectively.

People were provided with enough food and drink throughout the day.

Staff ensured people had access to external healthcare professionals when they needed it. People's changing health needs were monitored by staff.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed occasions when people were not treated with dignity.

People were not respected by staff as they lived in an environment which lacked cleanliness.

Staff let people make their own decisions about their care and they people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care plans were reviewed we found some information was incorrect or missing.

People were able to express their views and were given information how to raise their concerns or make a complaint.

People were supported to take part in activities which meant something to them.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Although the provider and registered manager had created an open, relaxed atmosphere in the home where staff felt supported, staff were not following policies and procedures correctly.

Relatives told us the registered manager and provider were very visible, however this had an impact on the day to day oversight of the home.

Staff were able to raise concerns and were encouraged to suggest new ideas.

The provider carried out regular quality assurance checks on the home.

Requires Improvement

Coombe Dingle Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 January 2015 and was unannounced. The inspection team consisted of two inspectors and one expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding to information and concerns that had been raised with us.

As part of our inspection we spoke with four people who lived at Coombe Dingle, three staff, two nurses, two relatives, one visitor, the registered manager, the provider and five healthcare professionals. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the two lounges, activities room and dining area.

As some of the people who lived in the home were unable to speak with us we spent a large amount of time during our inspection observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included five people's care plans, seven staff files, training information, medicines records and some policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We last carried out an inspection to Coombe Dingle in February 2014 when we found the provider was not compliant in some areas. We followed this up with an inspection in September 2014 and saw the provider had taken the necessary action to ensure compliance.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I've always felt safe here." Another told us, "There are always staff around." A relative said, "I know when I'm not here there's someone with him." However, our own observations and the records we looked at did not always show that people were safe.

People's medicines were not always managed so they received them safely. Staff told us they received medicines training and we confirmed this by looking at training records. Nursing staff were able to answer our questions in relation to one person's medicines. However we observed examples of poor practice by staff in relation to medicines. We saw one nurse give medicines to a person who had swallowing problems using a spoon. They put several tablets on to the spoon in one go which meant it was difficult for the person to swallow them. We observed a nurse go to one person's room and find them asleep. The nurse told us they would, "Leave for 30 minutes and go back to try again." This did not comply with best practice guidance which states medicines should be disposed of and a new dose made up when ready to be administered.

Staff did not follow the medicines procedure for the home. We read in the medicines procedure, 'administer one patient at a time'. However one nurse carried two people's medicines on the same medicines tray. Both glasses of medicines looked the same despite one of the medicines being added to a thickening agent. Neither glass was labelled meaning a person could be given the wrong medicine. The procedure also reads, 'never leave any types of medications on or around the drug trolley when left'. We found the medicines trolley unattended with medicines sitting on top. We noted the medicines policy was dated 2012. There was a review date of 2013, but this had not been done which meant staff may not be following the most up to date guidance.

People did not always receive their medicines on time. Although one person told us, "I get my medication when I need it." We saw people who should have their medicines at 08:00 not receive them until approximately 10:30. This was because only one nurse was dispensing the medicines. Staff told us people with conditions such as diabetes or hypertension were prioritised to ensure they received their medicines at an appropriate time.

There was a risk of abuse of controlled drugs (medicines that are controlled under the Misuse of Drugs legislation). Staff told us they had not read the medicines policy in relation to controlled drugs (CDs) and did not record when people had not taken them. Staff did not follow national guidance on checking CD stock regularly as they said they did not record or check stock every week. The CD book recorded that stock was last checked three weeks prior to the inspection.

The lack of proper medicines processes was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at risk of harm from staff not using the correct manual handling procedures or staff not taking appropriate action. We saw staff use a hoist to lift one person in an appropriate manner; however we did not always see staff use the correct manual handling procedures when assisting people to get up from their chair. We saw staff on two separate occasions hold people under their arm to help them up. This is an unsafe way to lift a person and leaves both them and staff at risk of harm. A healthcare professional told us they found one person leaning against their bed rails in their bed. They found this person's pressure mattress was faulty and losing air which meant the person may be at risk of developing pressure sores. Staff told them they had turned the alarm to 'mute' as it kept alarming. The healthcare professional told us staff seem totally unaware it was their responsibility to check the mattress.

People may be subject to physical harm because of the lack of proper manual handling practices is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were cared for by a sufficient number of staff to keep them safe and meet their individual needs. The registered manager said staffing levels were decided by her in agreement with the provider, based on the needs of the people living in the home. She told us that although there were currently less people living in the home than one month ago, they had retained the same level of staffing as some people now needed more care.

Staffing levels were in line with the information given to us by the registered manager. We were told the home used regular agency staff as some people required one to one

Requires Improvement

Is the service safe?

care. The registered manager explained they always used the same agency staff to ensure consistency. We spoke with one relative whose family member had one to one care from staff. They told us this was always provided.

People felt there were enough staff. One person told us, "You don't need too many staff. When I call for help they come, but I am quite happy sitting quietly and they let me." Another said, "I would say there are enough staff about." A further told us staff were busy but they didn't have to wait to be helped.

Appropriate and complete records were held in relation to people's medicines. We looked at two Medicines Administration Records (MAR) sheets and saw these contained people's photographs, were completed and signed correctly by staff and when people had refused their medicines staff has given explanations as to the reason why.

Action from a recent pharmacy audit had been completed. We looked at the last pharmacy audit and read actions had been identified as a result. For example, to include photograph identification on people's MAR sheets and to record the clinical room temperature daily. We checked whether these actions had been taken and found they had.

. Most staff had received safeguarding training. Staff understood the different types of abuse and described the action they would take if they suspected abuse was taking place. A flowchart was available for staff which showed how they should act if they had any concerns. Two staff members were able to verbalise their reporting responsibilities and said they would report and record the incident. Another staff member told us, "I would report to the manager if I see something unsafe. If it is serious I would tell CQC about it." There were 'Keeping you Safe' leaflets available for people and visitors.

Risk assessments had been drawn up to help keep people safe. These included controlled risks. For example, some people preferred to use the stairs, rather than the lift. This showed people were supported to continue doing things independently but staff made sure they could do so in a safe way.

The provider had a plan in place to deal with emergencies such as evacuation which helped to protected people. There was guidance for staff on what action to take in the event of fire. The home was staffed 24 hours a day and there were arrangements with a local home in the event the home had to be evacuated.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System (police) check, in addition to other required documentation, such as evidence of nursing staff being registered with the Nursing and Midwifery Council.

Requires Improvement

Is the service effective?

Our findings

People had freedom to choose what they wanted to do. One person said, "I just like to do what I want." Another told us, "I stay in my room or down here (lounge)." And a further commented, "I prefer being down here and they let me." People said they felt the care delivered to them was good and they could see the doctor or the chiropodist when they needed to.

Staff and the registered manager had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw some evidence of people having had a mental capacity assessment in their care plans and a relative said staff had involved them in the best interest meeting about using bed rails on their husband's bed. However, not everyone had received a mental capacity assessment when required. This meant decisions, which may have been made for someone who lacked capacity, may not have been made in line with the correct procedures. For example, one person climbed on people's beds during the day and staff had made a decision to raise one bed to shoulder height to avoid this. Staff were unable to tell us how this decision had been made, or whether it had been discussed during a best interest meeting. We were told, "We do that to stop the person getting on the bed." We discussed this with the registered manager and it was clear she was in the process of carrying out this piece of work. This is an area that needs to be improved upon.

The registered manager said no-one in the home was subject to a DoLS authorisation but they knew they would need to make an application should they wish to, or needed to, deprive someone of their liberty. There were no restrictions on people's movement and people could move around and leave the home when they wanted.

Staff received training in order to carry out their role. We were told essential training included dementia, epilepsy, safeguarding, first aid and manual handling. From the records we read most staff were up to date with this training. Staff told us they worked well together and received supervision and appraisals.

Training covered a range of topics, some of which were specific to caring for people who lived in Coombe Dingle. For example, most staff had received training in behaviours that challenge, dementia and pressure area care. The nursing staff had undertaken training in venepuncture (the collection of blood from a vein) and death verification. Some staff were trained in Makaton (the use of signs and symbols to communicate).

A healthcare professional who had been visiting the home weekly for the last two years told us they felt the nurses were skilled and knowledgeable in their role and followed any guidance given by them. Another healthcare professional told us many people had particularly demanding behavioural needs and staff tired hard to understand and they looked after people. Further healthcare professionals said staff took in any training they provided to them and they listened to guidance and followed it through.

The care staff provided was effective. One person had displayed behaviour which was difficult for staff to manage. Staff discovered this was because this person was getting out of bed too early in the morning. Staff allowed the person to stay in bed longer and as a result they were much calmer. Another person required one to one care from staff and this was provided.

People were provided with enough to eat and drink. Staff supported people to eat their lunch in the dining room and other people received lunch in their rooms. People who required a soft diet had this served to them in an appropriate manner and we heard staff offer people a choice of drinks. One person told us, "The food's okay. We get drinks when I ask for it." Another said, "The food is quite pleasant. I am not an enormous eater and there is always enough." A further person said the food was good and they got a choice.

People had a choice of food. The chef told us there was always a choice of two meals at lunch time and supper. We saw this on the day. However, we found the choices written on the menu board in the dining room were in small writing which would be difficult for people to read.

Staff identified risks to people with dietary needs and ensured the chef had up to date information. Staff got to know what people didn't eat. We read the information given to the kitchen staff which was updated regularly by care staff. The chef was able to tell us individualised dietary needs of people and what they would do if someone was losing weight.

The health needs of people were met as staff referred people to healthcare professionals as and when needed.

Requires Improvement

Is the service effective?

One person told us, "I don't need the doctor, but I can see him if I want." The local GP visited the home on a weekly basis and held a 'surgery'. This was open to the people at Coombe Dingle and also their relatives if they had any concerns about their family member. A relative said if there were any health problems at all with their husband, staff would call the GP.

Care plans evidenced the involvement from external health professionals to provide guidance to staff on a person's changing needs. We read people had involvement from the community psychiatrist, optician and speech and language therapy team.

Signs were located around the home to assist people in knowing their way around. We saw pictorial signs for the lounge, dining room, bathrooms and activity room. The lounge had a large board on which daily information was displayed, such as the date, year and weather to help aid orientation. The provider had developed a 'kitchen' area in the dining room for people and the activities room contained various items and activities for people to use. Each day the activities co-ordinator held a 'dining experience' which brought three or four people together in a quiet environment to have lunch together.

Requires Improvement

Is the service caring?

Our findings

People told us, “They are all very nice people. The staff look after me well.” And, “The girls are good and I chat with them a lot.” Other comments included, “The girls are reasonable. They are pretty good at looking after us all.” A relative said staff talked to their family member and felt that although they couldn’t communicate back, there was a, “Connection” between them and staff. A person told us staff were kind and caring. A healthcare professional commented they had seen a lot of positive interactions between staff and people when they visited.

When we asked people whether they were treated with respect we were told, “I expect them to respect me and others and they do. They are polite; they knock on my door when they come in.” Another told us staff treated them with dignity when giving care. However, we did not always observe this. Staff automatically put clothes protectors on people at lunch time without asking whether or not they would like them. When we were in one person’s room a staff member knocked on the door but did not wait for a response before walking in. People were wheeled around in arm chairs, without being moved to different seating when more appropriate. For example, during lunch two people were wheeled into the dining area in arm chairs and left to one side, whilst all others were at tables. This left people sitting at a lower level to other people and not able to sit at a table. We asked about one person and were told it was because they were not mobile and felt safer in the chair. However, a healthcare professional told us the arm chair should be in the person’s room and that they were able to transfer in order to sit in another seat. One person was brought into the lounge area and was not asked were they wished to sit and a carer was seen standing beside someone, not facing them, to feed them. There was no interaction and the carer talked to other staff whilst putting spoonful’s into the person’s mouth.

Staff did not always respond to people in an appropriate manner. We heard one person calling out, “Come here, come here” for a period of time, but staff ignored them. Another person liked to move around the home, but we saw staff constantly encourage this person to sit down. At one point this person led an inspector through the dining room to a small lounge area and staff tried to stop them doing this.

People were not respected as staff did not ensure people lived in an environment that was clean and fresh. Two commode chairs were stored in the upstairs bathroom. The vinyl covering of the chairs was torn and hanging off leaving the foam interior exposed. We saw two people in bed who had bed rails and found the bumpers were torn on one and worn away on another. The chair in this room was dirty and the cushion had no cover. There were stains around the base of toilets and stained carpet in the lounge. One room had dirty windows and the vinyl flooring had come away at the skirting in an upstairs bathroom. An en-suite bathroom had a rusty handlebar by the sink and we found stained bed frames in another bedroom. The bathroom on the top floor had enamel peeling around plug hole in bath, dirty grouting on the sink and stains on the floor. We saw a mouse trap on the floor in the corner. A further bedroom had a commode chair which was dirty around the base of the legs. Cleaning logs were seen for individual floors and shampooing of carpets as well as other cleaning tasks. However there was a strong smell of urine in the home when we arrived at the inspection. This remained in the home throughout the day.

Staff not always treating people with respect or dignity is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we saw staff attend to people in a prompt manner, although we saw that staff appeared rushed during the morning and had little time for social interaction. Most of the time staff were carrying out their duties only. In the afternoon and early evening, staff were more relaxed and had time to chat to people.

We did see some good examples of good care. We saw care delivered in a kind manner and heard staff use people’s first names and staff introduced us to people. One staff member spent 15 minutes encouraging someone to get dressed. They did this in a kind and patient manner. The registered manager interacted kindly with people regularly throughout the day.

We saw instances were staff treated people with compassion when they became upset and distressed and staff listened to people when they were talking to them. We observed some people choosing to remain in their rooms and others wishing to be in the lounge area in the company of other people and staff. People were given extra blankets and cushions in the afternoon to make them comfortable during a period of quiet time.

Requires Improvement

Is the service caring?

Relatives told us they could call unannounced and were always welcomed. One person said, “My family can visit sometimes.”

There was evidence in people’s care plans of people’s preferences and choices for their end of life decisions and staff involved relatives in the planning. One person stated they wanted a quiet and peaceful environment with music playing. Another person had a living directive and staff respected this by supporting the relative to ensure it was followed.

A healthcare professional said staff gave very good end of life care to people and they worked well as a team. They felt staff provided dignity to people and said staff did more than any others they knew. Another told us staff enabled people to die peacefully in the home, rather than being moved to hospital. People had access to specialist support and equipment, such as oxygen, to meet their end of life care needs. The registered manager told us they were working towards the Gold Standard Framework (GSF) for end of life care in order to train staff to give people a, “Quality end of life.”

Requires Improvement

Is the service responsive?

Our findings

People were encouraged to make their own decisions about their care. They told us the care seemed resident focussed.

People's decisions and choices were respected by staff. People had specific information about themselves in their room and how they liked staff to provide their care. For example, one person had 'please leave my night light on as I get scared at night'. Another person preferred to stay in bed some days and get up on other days as they found it too tiring to be up all the time. Some people preferred to go to bed early in the evening and other's liked to stay up.

People's care plans were regularly reviewed by staff and keyworkers were responsible for ensuring information was recorded in a care plan. Care plans contained information relevant to a person, such as information on indication of pain or reasons for weight loss. However, care plans were not always up to date. Three care plans had no history for a person or information about their likes and dislikes. We were later told the activities co-ordinator held information about people's life histories, but these had not been transferred to the care plans for all staff to be able to access. Another care plan included a statement that one person disliked spicy food and fish, however both the registered manager and chef told us this person had a good appetite and ate everything. This is an area that needs to be improved upon.

A relative told us they felt staff undertook individualised activities with people. We saw the activities room held various items relevant to people living with dementia, although we did not find there was much for people to look at, feel or engage with outside of this room. One person told us, "There's not a lot to do here." This was confirmed during the morning. We saw staff were rushed and people did not always receive much attention from staff. People were sitting or sleeping during the morning because of lack of stimulation. On several occasions when staff needed assistance with people during busy times, we saw this being provided by the registered manager, which meant the manager was taken away from their management duties. During the afternoon staff spent more time with people and interacted and spoke with them on an individual basis. A healthcare professional said they visited once and found the activities co-ordinator sitting with people, "Sorting out socks into pairs." They said that although it was a simple task, it was one several people were able to do and to join in with.

People were not socially isolated and staff supported people to take part in social activities. A church group visited in the afternoon and held a service and some of the people took part in the singing. One relative said their family member joined in with the musical session each month. The local horticultural society, Rotary club and Zoo lab (animal handling) had visited and the home had a befriender's scheme. We read guidance to staff for one person in relation to activities relevant to their past job. We were told by their relative that staff followed this guidance.

Staff responded to feedback from people regarding the service. The full time activities person was developing a new activities programme based on the personal information they had about a person and their likes and dislikes. This was being done following comments from relatives when activities did not take place because people were not interested.

People knew how to make a complaint or comment on an issue they were not happy about. One person told us, "If I was troubled about anything, I would say something about it." Another said, "If I need something, they help me." A relative told us they could approach staff and got on well with all of them. We looked at the complaints log and read the provider had responded to complaints in a timely manner. Complaint information was available to people in the main lobby of the home.

People were encouraged to leave feedback about the service. We read one compliment from a relative thanking staff for reorganising someone's day in order the person could attend a health appointment.

Requires Improvement

Is the service well-led?

Our findings

People were complementary about management. One told us, "I like that person; she is the (registered) manager." Another said, "I don't know the (registered) manager, but things seem to run okay." A healthcare professional told us the provider really cared and they saw them most weeks and the registered manager was, "Amazing." A relative said they saw the registered manager quite a bit. They told us she was hands on and very visible.

The registered manager said they were aware of the day-to-day culture in the home as they were out on the floor a lot. However, because of the time the registered manager supported staff this had an impact on their day to day oversight of the home and there was no evidence of delegation to other staff. Senior staff did not take responsibility for leading and setting a good example to care staff to follow good practice. For example, in relation to manual handling processes or treating people with respect and dignity. The registered manager told us they were behind on some work, for example completing mental capacity assessments on people. We felt this was because they were often taken away from their management duties by helping staff. This is an area that needs to be improved upon.

Staff told us they liked the management and said they were supportive. One staff member commented, "I like the employer, he is very supportive." A relative said staff addressed them by their first name which they preferred as it made them feel known to staff.

Staff attended English classes to improve their communication with people. The provider told us this was something they had introduced to help both the staff and the people they cared for.

Staff had a clear vision and set of values which were displayed in the main hallway of the home. One staff member said they aimed to, "Ensure a holistic approach to care which was individualised to resident's needs." The registered manager encouraged staff to talk to them openly and observed care being given. Staff meetings were held and we read the minutes of the last meeting which included a discussion on the Gold Standard Framework (GSF), infection control and the environment.

Staff received feedback from management which gave clear information on what action was needed. The registered manager gave us notes from a staff meeting where staff were reminded of their duty of care and what was expected of them.

People were cared for by staff who felt safe to raise issues that might impact on people's safety. We saw staff had a whistleblowing policy available to them in order to raise concerns.

People were actively involved in giving feedback about the service. We read the results of the most recent quality questionnaire. This had been completed by relatives. Seven of the 38 questionnaires were completed. The results showed relatives were very satisfied or quite satisfied with the way staff tried to help people, how their family member was looked after, the availability of staff, staff attitude and the nursing care, premises and management. Comments included, "I would like to take this opportunity of thanking all care staff, senior staff and the management for all the care and attention that is being given."

The provider and registered manager said key challenges to them were to meet the expectations of relatives and to maintain a good level of care. Some staff said their challenge was to find quality time to sit and spend time with people. The registered manager was undertaking the GSF for dementia and end of life to help ensure they had the skills to review the delivery and quality of care provided. A healthcare professional told us they had regular meetings at the home in relation to the GSF and they found the registered manager open and keen to work with them. The registered manager was investigating applying for charitable status for Coombe Dingle which would raise the profile of the home.

Care records and staff records were stored securely and confidentially but accessible when needed. The registered manager and staff were able to provide us with all the documents we requested without any difficulty, showing us they were aware of how to access policies and procedures. The registered manager was meeting CQC legal requirements by submitting notifications when appropriate.

Regular internal checks were carried out to check on the safety and suitability of the home. These included maintenance of equipment, the call bell system, boiler and water temperatures, alarm system and lighting. A book was

Requires Improvement

Is the service well-led?

available for staff to note down jobs for the maintenance person which he signed once he had completed the piece of work. The provider gave us a copy of their annual improvement and maintenance plan which was developed to drive improvement in the home.

The provider worked closely with the local GP who had recently completed a fellowship in dementia. Together they were looking at improving the environment to make it more appropriate for the people who lived there. For example, the interior was being redecorated, the flooring changed and signage improved.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had not ensured people were safeguarded against the risk of abuse by staff lifting people inappropriately.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider had not ensured staff were following appropriate procedures in relation to the management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **There were not suitable arrangements in place to ensure people were treated with respect and dignity.**