Care Quality Commission

Tamaris Healthcare (England) Limited

Castleton 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?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 19 May 2015 and was unannounced.

At the last inspection in October 2014 we identified that the provider had breached five regulations associated with the Health and Social Care Act 2008.

We found people did not experience care, treatment and support that met their needs and ensured their safety and welfare; there were not always effective systems in place to manage, monitor and improve the quality of the service provided. The registered person did not ensure staff received appropriate training, professional development, supervision or appraisal and did not take the necessary steps to ensure that, at all times, there were sufficient numbers of experience staff to meet people's health and welfare needs. We also found people were not always protected against the risks associated with medicines as appropriate arrangements to manage medicines were not in place. We issued the provider with a warning notice with regard to this.

Summary of findings

We told the provider they needed to take action and we received a report in December 2014 setting out the action they would take to meet the regulations. At this inspection we found improvements had been made with regard to these areas.

Castleton Care Home is a detached purpose built property located in the Wortley area of Leeds. The home provides care and support for up to 60 older people, some of whom are living with dementia or related mental health problems.

At the time of this inspection the home did not have a registered manager. The previous registered manager was de-registered in December 2014. 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.

The service had a very pleasant welcoming entrance, clean and fresh smelling, with pictures on the walls. En-route to the lounge we were met by a staff member who said, "We are very glad to see you." They went on to explain the staff had been working very hard to improve, things had improved and they were now keen to demonstrate that via an inspection. During our discussions, the regional manager explained they were working really hard to eliminate some of the problem areas in the home and were using learning from other homes in the group to improve things. The home manager had resigned and a replacement manager had been appointed. Until they could start, the regional manager was overseeing things, with the help of a quality assurance manager.

The home had significantly improved since our previous visit. We saw evidence of good relationships between people who used the service and staff who understood their individual needs. Activities for people were more meaningful and people were purposefully engaged. We saw staffing levels were now determined by the use of a dependency tool and these were maintained and staff received regular supervision and training which helped to support people safely. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines safely.

People, their relatives and staff gave positive feedback about the service and how it had improved over recent months. The manager had improved the quality monitoring of the service, which enabled them to drive improvement.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support. Mental capacity assessments had been completed and the service had made Deprivation of Liberty Safeguards applications where appropriate.

Robust recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work.

People were happy living at the home and felt well cared for. People had good experiences at mealtimes and received good support that ensured their health care needs were met. Staff were aware and knew how to respect people's privacy and dignity.

People told us they felt safe and knew how to make a complaint if they needed to. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe.

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 safe.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

People told us they felt safe. The staff we spoke with knew what to do if abuse or harm happened or if they witnessed it. Individual risks had been assessed and identified as part of the support and care planning process.

Staffing levels were sufficient to offer support and meet people's needs. The recruitment process was robust, which helped make sure staff were safe to work with vulnerable people.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines safely.

Is the service effective?

Good

The service was effective.

People were given choices in the way they lived their lives and their consent was sought in line with legislation and guidance. Staff had an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff training and support provided equipped staff with the knowledge and skills to support people safely. Staff completed an induction when they started work.

People enjoyed their meals and were supported to have enough to eat and drink and received appropriate support with their healthcare.

Is the service caring?

Requires improvement

The service was caring.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

People valued their relationships with the staff team and felt they were well cared for. Staff promoted positive caring relationships.

Staff understood how to treat people with dignity and respect and were confident people received good care.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support.

There was opportunity for people to be involved in a range of activities within the home and the local community.

Complaints were responded to appropriately and people were given information on how to make a complaint.

Is the service well-led?

Requires improvement 

The service was well led.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Improved systems were in place within the organisation to regularly monitor and review the quality of the service.

There was an improvement in staff morale and staff reported a more cohesive way of working within teams to help drive improvement.

Castleton Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 May 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, a pharmacy inspector, a specialist advisor in Dementia and an expert by experience in people living with Dementia and older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 29 people living at the home. During our visit we spoke with seven people who lived at Castleton Care Home, four relatives, eight members of staff, the regional manager and the quality manager. We also spoke with one health professional who was visiting the home. We observed how care and support was provided to people throughout the inspection and we observed lunch in the dining room. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records and quality audits. We looked at four people's care plans and nine medication records.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. We were aware of concerns that the local authority and safeguarding teams had and their on-going investigations at the home. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires improvement

Is the service safe?

Our findings

At the last inspection we rated this domain as inadequate. The provider did not have arrangements in place to ensure the safe management of medicines and there were not sufficient numbers of suitably qualified, skilled and experienced staff to meet people's health and welfare needs.

The provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

People we spoke with told us they felt safe in the home and did not have any concerns. One family member told us, "I am happy she's safe and with the care she's getting."

We spoke with members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. All the staff we spoke with told us they had received safeguarding training. Staff said the training had provided them with enough information to understand the safeguarding processes that were relevant to them. The staff training records we saw confirmed staff had received safeguarding training.

The service had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. This helped ensure staff had the necessary knowledge and information to help them make sure people were protected from abuse.

People's individual risk assessments were up to date within their personal care files. We saw risk assessments had been carried out to cover activities and health and safety issues. We saw personal emergency evacuation plans were in the fire log book held at main reception. It was however, noted these required updating, as it showed people living on the ground floor of the building. We saw the provider's business continuity plan dated April 2014. This also contained details of how people should be evacuated in the event of an emergency and this required similar updating. The regional manager told us they would address this and these were updated on the day of our inspection.

We saw certificates were in place for the fire detection and alarms systems and the hoists and slings had been inspected. Portable appliances had also been checked.

We noted the last fire risk assessment had been carried out in October 2014. We saw a communication from the provider's estates team stating that from 1 June 2014, these were to be carried out by an external qualified estates contractor. However, we were unable to see when the next risk assessment for the home had either been carried out or arranged. We saw the fire safety policy dated December 2010 and were informed the provider was currently reviewing this policy. Details of the number and frequency of fire drills were held by the maintenance worker, who was unavailable on the day of the inspection.

Staff we spoke with told us staffing had improved and there were now consistent staff working in the home. This meant people's care needs were better met through consistency of staff caring for them. Staff reported improvements in team work as a result of having regular staff on duty and we saw evidence of much stronger teamwork throughout the home. One staff member told us, "Staffing is a lot better even on a weekend." Another staff member told us, "Good to have more staff so that staff are not so tired." One member of staff said, "Staffing is ok but sometimes sick is not covered." One staff member told us, "Sometimes there is not enough staff on a weekend but there is no impact on care." A relative we spoke with said, "There are plenty of staff, Monday to Friday but it's not so good at weekends and it's very difficult to get access. Only two carers for 29 residents and they have to break off to allow visitors to access/exit. Sometimes we have to wait 15 minutes to get in." One person who used the service told us, "My door won't close properly as the flooring has become loose and it's over a week since my daughter told them. They seem short staffed all the time." We spoke with the regional manager about the staffing levels on a weekend and they said they would look at this and address the person's flooring.

We saw staffing levels had been assessed using a dependency tool to ensure they were safe and there were sufficient staff to meet people's needs. The dependency tool was used to determine staffing levels and was based on the overall needs of people who used the service. The assessment considered people's dependency alongside the environment, layout of the building and any specific

Requires improvement

Is the service safe?

needs people may have such as one to one support. The manager showed us recent records which indicated the home was currently staffed appropriately based on the calculations of the dependency tool.

We found staffing levels were sufficient to meet the needs of people who used the service on the day of our visit. The regional manager told us the staffing levels agreed within the home were being complied with, and this included the skill mix of staff.

We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

At a previous inspection in October 2014, we found that the medicines were not handled, recorded or administered safely. This placed people who used the service at risk of harm. We issued a warning notice requiring the provider to take swift action to improve the management of medication within the home. At this inspection we found significant and sustained improvements had been made to the systems in place for recording and managing medicines and this meant that people were now protected against the risks associated with the administration of medication.

We looked at a sample of medicines, Medication Administration Records (MARs) and other records for nine people living in the home. We spoke with two nurses about the safe management of medicines. We also spoke with a care worker about how creams and nutritional supplements were used. We observed medicines being prepared and administered at different times of the day. We reviewed medication records for fifteen people living in the home.

Medicines were stored safely at the correct temperatures and were locked away securely to ensure that they were not misused. Medicines, including controlled drugs (strong medicines with extra storage and recording requirements), could be accounted for easily as records were clear and accurate; this meant we were able to see that people had been given their medicines correctly. We saw there was an effective system of stock control in place and this helped to reduce the risk of people running out of their medicines.

Risk assessments and care plans were in place to support people who wished to look after some or all of their own medication. We saw regular reviews were undertaken to check the person continued to take their medicines safely and to ensure nurses and care workers continued to offer an appropriate level of support, whilst maintaining the person's independence.

Some people were prescribed medicines, such as painkillers or laxatives that were only to be taken 'when required'. Clear guidance was kept with the medicines records detailing when and how these products should be used to enable nurses to support people to use their medicines safely whilst having due regard to their individual needs and preferences.

A mental capacity assessment and 'Best Interest' decision had been completed in line with current guidance and the Mental Capacity Act 2005 for one person who needed to be given their medication in their food. This was necessary because the person lacked the capacity to make an informed choice about refusing their medicines. Records showed the decision had involved both the doctor and the person's family, and advice had been taken from a pharmacist to ensure the medicines could be safely given in food. Clear instructions were available for nurses to follow to make sure the medicines were offered and administered as agreed.

Medicines were only handled and administered by nurses, although care workers were responsible for applying and recording most emollient and barrier creams (for skin protection). We spoke with a care worker about the system in place for applying and recording these creams. They told us nurses personally checked people's skin integrity and also regularly reviewed records to make sure the care workers had applied creams as prescribed.

Regular audits (checks) were carried out to determine how well the service managed medicines. We saw evidence that where concerns had been identified, action had taken to address the concerns and further improve medicines management within the home.

We noticed the environment was well maintained and improvements had been made to the décor. We saw cleaning staff carried out their duties throughout the inspection and as a result the home was clean and odour-free.

Good

Is the service effective?

Our findings

At the last inspection we rated this domain as requires improvement. Staff did not complete a comprehensive induction when they started work or have the opportunity to attend regular supervision meetings so the provider could not be sure they understood how to deliver care safely and to an appropriate standard. Following the last inspection the provider sent us a plan which identified how they were going to improve the service. At this inspection we saw they had followed their plan and appropriate systems were in place to make sure people's rights were protected and staff received appropriate support.

We looked at staff training records, which showed staff had completed a range of training sessions. These included basic life support, medication, fire awareness and infection control. Staff told us they had been supported to undertake a variety additional training such as emotional awareness and Dementia awareness. The training records did indicate staff received regular training and a staff member told us a mechanism for monitoring training and what training had been completed and what still needed to be completed by members of staff was in place.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff we spoke with confirmed they received supervision where they could discuss any issues on a one to one basis. They told us they also received group supervisions. For example, we saw group supervision was conducted in May 2015 regarding the new regulations. They also said they had completed the appraisal process. When we looked in staff files we were able to see evidence that each member of staff had received supervision on a regular basis and each staff member had a completed an appraisal. Two staff members said, "We are given training for our jobs and have regular supervision sessions." Another staff member told us, "There has been more regular supervision and more opportunity for training."

We were told by the regional manager staff completed an induction programme, which included information about the company and principles of care. We looked at staff files and were able to see information relating to the completion of induction.

The Mental Capacity Act (2005) provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The staff we spoke with told us they would always seek the consent of people before they carried out any personal care interventions. Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support.

Staff told us they had received training in Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). We saw from the training records that staff had completed the training and further Mental Capacity Act (2005) training had been arranged for June 2015.

Mental Capacity assessment records we looked at provided evidence that, where necessary, assessment had been undertaken of people's mental capacity to make particular decisions. We saw an assessment regarding the decision to live in a care home in one person care plan. This meant that people's rights had been protected as unnecessary restrictions had not been placed on them and any decisions had been made in their best interests.

The Care Quality Commission is required by law to monitor the operation of the DoLS which provide legal protection for vulnerable people if there are restrictions on their freedom and liberty. Documentation we looked at showed the appropriate authorisations were in place and staff had been trained on DoLS. Staff were aware of who had a DoLS in place and what that meant for the person's care and support delivery.

People were supported to have sufficient to eat and drink and maintain a balanced diet. We observed the lunch time meal, which was well organised and a pleasant experience for people. We saw the menu for the day on the notice board. We observed the staff explaining to each person what choices were on offer and they did not rush in doing this. The food looked hot and nutritious and distribution was well organised, with happy interaction between staff and people who used the service. Hot and cold drinks were offered before and after lunch. Some people had their meal in their room and a staff member told us this was their choice.

People appeared to be enjoying their meals and were given friendly support and encouragement to eat where needed, but were offered assistance if needed. This was done in a

Good

Is the service effective?

respectful and caring way, with evidence of individual preferences known by the staff. Staff asked every person whether they would like tea or coffee and what sort of sandwich they preferred. We heard one staff members ask one person, "Would you like me to help you?" We also noted the staff member provided a cushion to one person whose sitting posture needed more support and in general all staff addressed people by their names when speaking to them, often repeating what was said if they had not heard or understood. People were asked if they had eaten enough, or if they wished for something more to eat.

We observed the 'social lunch' where four people were offered the chance to eat in the downstairs café with two staff members. Conversation was about activities/events past and present as well as reminiscences and people clearly engaged and enjoyed it.

One staff member told us, "Food has improved and there are enough staff to support people when needed." Another staff member told us, "The food has improved and there is a lot of choice." One member of staff said, "Food is good." However, two staff did say there was fish five times per week and people were getting fed up with fish. People we spoke with said the food was ok although some described it as mediocre. One person told us, "Breakfast is the best meal but the rest is not really to my taste. We can only have what's on the menu." Another person said, "Meals are terrible, can't eat them love, but now I've opened up a bit and tell them; when you think what it costs to live here. We have a choice but I make the wrong one." The regional manager told us they were going re-look at the menu.

People who used the service and their relatives said that if necessary a doctor would be summoned. One person told us, "A nurse comes and dresses my leg and the doctor drops in from time to time." One person said they had been suffering with a rash and staff had taken appropriate action. Another person said, "They brought the doctor when I wasn't well." One relative we spoke with said, "They telephoned me when my mother wasn't well and told me doctor had been called. When she's poorly, they always get in touch."

We saw the provider involved other professionals where appropriate and in a timely manner. These included GP, opticians and dieticians. We saw when professionals visited, this was recorded and care plans were changed accordingly. One staff member said, "Chiropody come in every two to three months."

A health professional from the local GP's surgery was present in the home on the day of our inspection and they said the care had improved over the last few months and although they tended to focus on end of life care, they had been supporting staff by visiting weekly and arranging referrals to other agencies, such as dietician, and giving general advice and support where needed.

Requires improvement

Is the service caring?

Our findings

At the last inspection we rated this domain as inadequate. We found members of staff were not following people's care plans and therefore, people's care and support was not always delivered in a way that met their needs. We also found people's individual needs were not always appropriately responded to by staff.

At this inspection we found the provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

People told us they were happy and well cared for although three separate comments were made about 'sometimes they are in a mood'. One person said, "Staff get moody sometimes; just ignore you, so I say excuse me and they answer me." One person said they like living at Castleton Care Home. They said, "I'm as happy as a bird in a cage."

One relative we spoke with said, "My mum has been at Castleton for two years and I've no complaints, the staff talk to you, they are sociable. Mum has regular weigh ins and she always looks clean." Another relative told us, "My mum was relocated to Castleton when another home closed. She had problems settling in initially but I spoke to the manager and suggested she had a one to one carer. She agreed and now she's got [name of staff member] who is lovely. Mum loves her."

We found the home was very welcoming with a relaxed and friendly atmosphere. The care we saw was very good with lively and jolly interaction between staff and people who used the service. We observed staff spoke with people in a caring way and supported their needs. Staff responded to people swiftly and respectfully when they asked for things and they appeared to know people well. We observed a number of occasions where people asked to go to the toilet and were taken straight away. We saw a number of people were supported to have a bath and returned happy. One person told us, "They help me to have a bath twice a week before bed. I have no problems, I am looked after ok." One staff member told us, "They can have a bath when they want, or a shower."

People looked well cared for. They were clean and tidy which was achieved through good standards of care. We saw the gentlemen were clean shaven.

Staff we spoke with told us, "Care has improved. Everyone is well looked after and there are no risks." One staff member said, "Care is good, people are well looked after." Another staff member said, "Care is done well and we put 100% into looking after residents. The residents come first."

We saw people were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. The premises were spacious and allowed people to spend time on their own if they wished. One person said, "I like [name of staff member], he is always interested in what I have to say. I can chose when I go to bed and what time I get up. Staff are generally kind."

The home operated a key worker system for the people who used the service which was in the process of being updated to reflect staff turnover. When asked, the care staff explained although there was no extra time allocated for this role, it involved mainly ensuring a person's personal effects and supplies were in order and liaising with their relatives.

Staff treated people with dignity and respect. One staff member said, "I knock on people's door and make sure I close the curtains when I need to." We saw each bedroom had a 'care in progress – do not disturb' note to hang on people's bedroom doors when required. Two relatives we spoke with said they felt their relative was treated respectfully and had seen her being moved out of the activities room to her bedroom in a dignified manner. However, we did see one person was being supported by two staff members to move from a comfy chair to a wheelchair in the living room. We noted other people and staff members in the living room at the time were watching this. Staff did not attempt to help or interact with other people in the room to distract them and to help maintain the person's dignity. We spoke with a staff member about this who said they would discuss this with other staff members.

Relatives were coming and going throughout the day without restriction. One relative said, "We are always welcome and if we are here at mealtimes we can have one with my mum and we can come at any time."

Good

Is the service responsive?

Our findings

At the last inspection we rated this domain as requires improvement. Activities were not always stimulating and meaningful and complaints were not always documented or responded to appropriately. Following the last inspection the provider sent us a plan, which identified how they were going to improve the service. At this inspection we saw they had followed their plan and appropriate systems were in place to make sure activities were more meaningful and there was systematic monitoring of complaints.

We saw the provider undertook pre admission assessments before people moved into the home. This ensured the service could meet the needs of anyone in their care. We found care plans were detailed and contained information that staff needed to provide effective and kind care. Care plans we looked at had sections at the front which were titled 'hotspots' and these showed areas of special concern such as medical history, medical conditions and if a 'Do Not Attempt to Resuscitate' order (DNAR) was in place. This enabled staff, in an emergency, to see relevant information at a glance.

We spoke with staff about how they cared for the people they supported. Staff were knowledgeable about people's needs and how care should be delivered. All staff said they had access to care plans so they could update themselves.

We saw from the care plans we reviewed that appropriate assessments of care were undertaken, reviewed and adjusted to the changing needs of the people in the home. The evaluations of care were informative and outlined the changes in people's condition and the consequent changes required to their personal care or medication. Care staff told us they had shift handovers, which kept staff informed of any planned appointments or events that needed to be considered when delivering care for particular days.

One care plan we looked at showed a DNAR had been in place from 20 November 2014. The GP had written 'indefinite' in the review date column. There was a statement saying the person wanted to be resuscitated in the end of life care plan, but a later entry, dated 28 November 2014, stated the person's 'daughter-in-law does not agree with [name of person] end of life needs. A meeting will need to be arranged to sort this out'. There was no further evaluation of this and no evidence of the meeting being arranged or held. We fed this back to the regional manager, who assured us this would be done as a matter of urgency to ensure the person's wishes were adhered to

We saw moving and handling assessments had been completed and monthly or weekly weights were recorded and acted upon as required. There were advance and end of life care plans, which were reviewed regularly. Body maps were regularly completed and updated as necessary and tissue viability service were contacted when advice was needed on the correct course of treatment.

We saw there was evidence of staff liaising with people who used the service and relatives regarding care and personal preferences in the care plans we looked at. For example, a relative requested her father should not wear a pad at night and the staff on duty informed the night staff. We also saw there was evidence to show that relatives were informed when people were moved to rooms on the first floor.

We looked at the complaints log and noted five complaints had been recorded since our last inspection. Of these, one was being investigated by the police and three by the regional manager. We saw the complaints policy, which had been reviewed in March 2015. The complaints we looked at had all been dealt with in accordance with this policy. For example, they had been acknowledged within two working days and a response had been sent within twenty working days and where this had not been possible, an explanation had been given.

The staff we spoke with told us they would report any concerns or complaints made by people who used the service to either a nurse, senior carer, deputy manager or to the manager.

The activity co-ordinator told us people living at the home were offered a range of social activities. We saw information for up and coming events at the home. These included arts and crafts, clay modelling, baking, knitting and sewing, movie afternoons, war time sing a long and an activities themed day. One person told us, they were taken out to visit the pub every week until midnight, by his friend and the care plan reflected this was an important part of their life and brought him great enjoyment. Another person told us, "I go out in the minibus regularly and never had any problems." One person however, said, "I'm never taken out, I'd like to. It's all old fashioned stuff, I like rock and roll."

Good

Is the service responsive?

One person relative told us, “They have a minibus and take them out in turn for outings to the pub for lunch or shopping. We take [name of person] out twice a week so they work with us so she goes with them on the days we don’t come. They also have activities which she likes.”

We observed the ‘happy day’s activities’. Initially there were chair exercises to music, followed by a war time sing-along, with song sheets provided in large type and union jacks. We saw all the people happily taking part and where anyone had difficulty, staff supported them. There was an external provider, two activity co-ordinators and a number of care staff who also joined in the fun. The activity finished with care staff and people dancing. We saw very good interaction. Craft and art was planned with one to one individual activity sessions during the afternoon.

We saw one person become distressed and the activity co-ordinator calmed them down by telling them where they were. They then provided the person with a sheet of paper with her address written on it in case they needed reminding.

The activity co-ordinator confirmed they did a lot of work within the local community, lunch at the community centre, summer fayres. They told us, “I love my job now, it all changed eight months ago. It’s fantastic I get support and a budget to work with. Staff now work together and join in. I’m hoping to get my activity room renovated.”

Requires improvement

Is the service well-led?

Our findings

At the last inspection we rated this domain as inadequate. We found there were not always effective systems in place to manage, monitor and improve the quality of the service provided. There were no effective incident and accident monitoring systems in place.

At this inspection we found the provider had taken appropriate action and was now meeting legal requirements. While improvements had been made we have not rated this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

At the time of our inspection the manager was not registered with the Care Quality Commission and had just left the service. The regional manager worked alongside staff overseeing the care given and providing support and guidance where needed. They engaged with people living at the home and were clearly known to them. A new manager was due to start at the home in June 2015.

People who used the service and visiting relatives said they felt comfortable and at ease discussing issues and care with the staff. One person's relative told us, "[Name of person] has been here a year and its good now." Another relative told us, "Before my mother was moved they rang and asked if it would be ok. The manager has just left and they sent us a letter to keep us informed. They didn't have to do that." Two relatives we spoke with said, "They felt that many problems were due to staffing and the number of staff that had come and gone recently." One relative said, "Since your [CQC] last visit they have tried to sort things out." Both relatives said the home needed someone who would come and stay, who had practical experience and managerial skills and who knew what they were doing. They said they had difficulty getting in or out of the building as there was no one on reception. They said they could wander anywhere downstairs and do anything as there were no staff downstairs now. The regional manager told us they would address these issues.

Staff spoke highly of the previous manager and said they had been very approachable and supportive. They said they were now kept informed by the regional manager of all changes that were appropriate to them and their role. One staff member said, "It is a better atmosphere. Staff and management are working together better" and "It still feels positive even though the manager has gone." Another staff member said, "It is calmer, staff are working together more and I feel involved with the management changes" and "Everything has improved 100%." Other comments included, "It is a million times better and I get a lot of support from the manager. We are more of a team and help each other. No tension. I am happier now working here, I love this job now" and "Things have improved. Good team spirit." It was clear from our observations that staff were happy in their roles and there was evidence of team work, particularly in the dining room and when taking people for baths.

One staff member said they knew about the 'whistleblowing' policy and they could take any concerns to the nurse in charge and if there was no satisfactory result, then they would take it to the manager.

We saw a monthly record of incidents had been kept since our last inspection. Incidents recorded included, medication errors, falls, pressure ulcers, expected deaths, infections, weight loss and physical abuse. Entries were up to date, the latest one being 10 May 2015. A monthly accident analysis had been completed between October 2014 and April 2015. Action plans had been prepared for those people experiencing multiple incidents. We checked an entry for one person who had experienced two falls in February 2015. The recommended action being, 'refer to falls team by 6 March 2015'. We looked at this person's care plan and saw that both incidents had been entered in the daily log on the days the incidents occurred. However, there was no evidence to show a referral had actually been made to the falls team. The regional manager said they would follow this up.

We were shown a software programme recently introduced by the provider, where tablet computers could be used for staff, relatives and visiting health care professionals to record their views on the quality of service and care, as well as the environment. One such tablet computer had been located in the main reception area and efforts were being made to encourage greater use of this, especially by relatives. The package also allowed the provider to conduct a series of daily, weekly, monthly, quarterly and half-yearly checks. These included a daily walk around and medication check. There were weekly care file audits and monthly housekeeping checks. Health and safety and home governance checks were conducted quarterly and information governance checks were carried out twice a

Requires improvement

Is the service well-led?

year. The process had been introduced in March 2015, but in the opinion of the regional manager, the information gained was already proving invaluable in gauging the quality of care and assessing where improvements were needed.

We spoke with another home manager visiting Castleton Care Home on the day of our inspection and they said the system was beneficial in that, with appropriate training, parts of the programme could be delegated to key staff, so that the manager was able to devote more time to other important areas of their service, as well as encouraging staff to get involved in the quality process. There was evidence in the notes of staff meetings to show that good practice and areas requiring improvement had been discussed.

We saw reports had been prepared by a member of the provider's quality team in April and May 2015. Areas covered included: medication, new care plan documentation, cleanliness of the home, soft furnishings, and the Mental Capacity Act (2005) and DoLS. We also saw a series of audits carried out by the provider's care quality facilitator, covering the period February to April 2015. These included: medication, the environment, care plans and activities. A dementia care advisor carried out a visit on 3 March 2015 and the areas checked included activities, staff interactions with the people they were caring for and the dining experience.

In March and April 2015, people were asked their views on the food service. A total of 29 responses were received. The questions covered the quality and quantity of food, choice and timing of meals and the variety of food available. Although the responses had yet to be analysed, the general opinion seemed to be that people were satisfied with the food service. However, more than 90% responded "No" to the question, "Does the chef discuss meals with you at meal times on a regular basis?" More than 80% said they found the quality of food good and almost 95% said they were satisfied with the quantity of food.

The regional manager had conducted three quality checks in November 2014, and February and April 2015. Areas covered included: staffing, a vulnerable adult list, quality of life, the new quality systems package and training.

We saw five sets of staff meeting notes covering the period December 2014 to May 2015. We also saw notes of two nurse's meeting held in February 2015 and a meeting of the night staff had been held in April 2015. Staff we spoke with told us they attended team meetings and one member of staff told us they had attended a meeting about the manager leaving and they felt involved in decisions about the future of the home and they had received a thank you letter from the provider.

Relatives we spoke with confirmed there were regular residents' meetings. However, one relative said they were always in the mornings which were difficult for some relatives who worked. We saw relatives' meeting minutes dated December 2015, January 2015 and April 2015. We saw topics discussed included moving people to different rooms, empty beds, activities and management arrangements.