

## Care UK Community Partnerships Limited







# Scarlet House

### Inspection report

123 Westward Road  
Ebley  
Stroud  
Gloucestershire  
GL5 4SP  
Tel: 01453769810  
Website: www.careuk.com

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#### Ratings

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

#### Overall summary

This inspection was conducted over two days on the 17 and 18 March 2015 and was unannounced. Scarlet House can accommodate up to 86 people. At the time of the inspection there were 42 people living in the home. The home had opened in September 2014.

Scarlet House was divided into four units. There were two residential units on the ground floor, a nursing and a dementia unit on the first floor. Each unit was self-contained with a lounge, kitchenette, dining area and

activity rooms. Staff were designated to work in a particular area to provide the care support to people. Nursing staff were working in both the nursing and dementia unit.

There was a registered manager working at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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.

People's medicines were not always managed safely. People were protected against abuse because staff had received training on safeguarding adults and they knew what to do if an allegation of abuse was raised. People were observed moving freely around their home.

People received a safe service because risks to their health and safety were being well managed. Staff were aware of the potential risks to people and the action they should take to minimise these.

People were receiving care that was effective and responsive to their changing needs. Care plans were in place that described how the person would like to be supported and these were kept under review. Some improvements were required as there were gaps in recordings on the delivery of care for people. This included food and fluid intake and positional changes for people.

People had access to healthcare professionals when they became unwell or required specialist help. They were encouraged to be independent and were encouraged to participate in activities both in the home and the local community.

People were treated in a dignified, caring manner which demonstrated that their rights were protected. People confirmed their involvement in decisions about their care. Where people lacked the capacity to make choices and decisions, staff ensured people's rights were protected. This was done through involving relatives or other professionals in the decision making process.

Staff were knowledgeable about the people they were supporting and spoke about them in a caring way. Staff had received suitable training enabling them to deliver safe and effective care. Newly appointed staff underwent a thorough recruitment process before commencing work with people.

The service was well led. There was a team that was supported by a registered manager. Staff confirmed they received support and guidance from the management of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We completed this inspection at a time when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in force. However, the regulations changed on 1 April 2015, therefore this is what we have reported on. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

We found there were some areas that needed to improve to ensure people were safe. This was because some people's medicines were not managed safely.

People were protected from the risk of abuse. This was because there were clear procedures in place to recognise and respond to abuse. Staff were trained in how to follow the procedures.

People were cared for in a safe environment that was clean and regularly maintained.

People were protected from being cared for by unsuitable staff as a thorough recruitment process had been completed.

Requires Improvement



### Is the service effective?

We found there were some areas that needed to improve to ensure people's care was effective. There were some gaps in the recording of care delivery which may put people at risk.

People's rights were upheld and they were involved in decisions about their care and support. Staff were knowledgeable about the legislation to protect people in relation to making decisions and safeguards in respect of deprivation of liberty.

People were supported by staff that knew them well and had received appropriate training. Other health and social care professionals were involved in the care of people and their advice was acted upon.

Requires Improvement



### Is the service caring?

People were cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their approach.

People and their relatives were actively asked for their opinion about their care through regular meetings. People's views were listened to and acted upon.

Good



### Is the service responsive?

The service was responsive. Staff were knowledgeable about people's care needs. Care plans clearly described how people should be supported. People were involved in developing and reviewing these plans.

People were supported to take part in regular activities both in the home and the community. This included keeping in contact with friends and family.

People could be confident that if they had any concerns these would be responded to appropriately.

Good



# Summary of findings

## Is the service well-led?

The service was well led. Staff felt supported and worked well as a team.

People, their relatives and staff commented positively about the leadership of the home and were confident they felt listened too.

There were systems to monitor the quality of the service. Checks were carried out to ensure care was delivered safely and effectively.

Good



# Scarlet House

## 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 was the service's first inspection since registering with the Care Quality Commission in September 2014.

This inspection took place on 18 and 19 March 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience who had experience of supporting people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at the information we had about the service. This information included the

statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not asked the provider/ registered manager to complete their Provider Information Record (PIR) in this instance. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

During the inspection we spoke with 15 people and six relatives. We spoke with the registered manager and ten members of staff.

We looked at seven people's care records, four staff recruitment files and training records, key policies and procedures and other records relating to the running of the service. .

After the inspection we made contact with four visiting health and social care professionals requesting feedback about the quality of the service. We received one response.

# Is the service safe?

## Our findings

People told us they felt safe and secure. One person told us “I feel much safer here than at home, the staff regularly check me during the day and at night. Staff check me two or three times during the night and this makes me feel safe, I don’t like to close my bedroom door and staff respect this”. Relatives and friends felt that the service was a safe environment. A relative told us “I have been impressed by the staff and their care, everything is so clean and tidy, and I know my mum is safe”.

People told us they received their medicines on time and staff told them about the medicines they were taking. However, we found medicines were not always managed safely. There were gaps in recording where medicines had not been given for three people on the 22 and 24 February 2015. Another person’s medicine had changed on the 11 March 2015 from being an ‘as and when required’ medicine to twice daily. A member of staff had recorded this on a ‘post it note’ instead of recording this clearly on the medicine record. From talking with a member of staff a further person had been prescribed cream for a medical condition. This was not clearly detailed on the medicine administration record as the instructions did not fully describe why it been prescribed or where it should be applied.

We found that the registered person had not protected people against the risk of unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines, which corresponds to regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

Medicines were kept safely and were stored securely. Staff had been trained in the safe handling, administration and disposal of medicines. All staff who gave medicines to people had their competency assessed by the registered manager. The medicines were checked monthly by a designated member of staff. There were policies and procedures to guide staff on the safe administration of medicines.

People received a safe service because risks to their health and safety were well managed. This included risks due to choking, poor nutrition, pressure wounds, risk of falls and

the delivery of personal care. Where risks were identified, care plans were put in place which provided information to staff on how to keep people safe. These had been kept under review and updated as peoples’ needs had changed. Where people required assistance with moving and handling, the equipment to be used was clearly described along with how many staff should support the person to ensure their safety. Staff confirmed they received training in safe moving and handling procedures.

Staff told us they had completed training in safeguarding adults and were aware of what constituted abuse and the importance of sharing information where they had concerns. Staff confirmed they would report concerns to the registered manager or the registered nurse/team leader in charge and these would be responded to promptly. They told us there were policies on responding to an allegation of abuse and whistle blowing. Staff were aware of the role of the Care Quality Commission where they felt their concerns had not been acted upon.

The home was clean and free from odour. All staff had received infection control training. Policies and procedures were in place to guide staff on safe practice. Domestic staff were employed to assist with the cleaning of the home. People and relatives confirmed the home was always cleaned to a high standard and there were no lingering odours.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and training to meet the needs of the people living in the home. However, staff working in the nursing area said it can be particularly busy as some people required two staff to assist them with personal care and to support them with daily exercises. Staff told us this could take up to any hour which meant that other people may have to wait. People told us they did not feel rushed and felt they were supported well. The registered manager explained the dementia unit had recently opened with four people from the nursing wing moving to the dementia unit along with some of the staff. They said this may have given the perception there were fewer staff. At the time of inspection there were two registered nurses and four care staff working in the nursing unit supporting 12 people. Eight of those people had been assessed as being high dependency and needing two staff to assist them.

The Registered Manager showed us the staff duty rotas and explained how staff were allocated on each shift. The rotas

## Is the service safe?

confirmed there were sufficient staff on shift at all times in all areas of the home. The manager told us staffing levels were assessed depending on people's need and occupancy levels. The staffing levels were then adjusted accordingly.

We were told recruitment of staff was on going as new people were admitted to the home. This was because the home had planned their rate of admissions to ensure suitable staff were working in the home and not to compromise the safety of people. The registered manager told us two further activity co-ordinators were due to start along with an additional six care staff, two registered nurses and four housekeeping staff. The registered manager told us they were planning to build in a twilight shift so there was additional staff at peak times to support people with getting up in the morning and getting ready for bed.

Staff confirmed where there was a shortfall, for example staff absence this was covered by existing staff. They said this ensured there was continuity in the service and peoples' needs were met. Staff confirmed the use of agency was rare.

The provider followed safe recruitment practices. We looked at the recruitment files for four members of staff and found appropriate pre-employment checks had been completed. All members of staff had at least two satisfactory references and had received a Disclosure and Barring (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Checks had been completed on the nurses to ensure they were registered with the Nursing and Midwifery Council (NMC). This meant the provider could be assured the nurses were fit to practice.

# Is the service effective?

## Our findings

People and their relatives spoke positively about the care and support they were given by the staff team. Comments included “The staff are lovely, really friendly and I cannot fault it here”, “Mum looks fabulous and cared for, it gives me confidence that she is happy” and “My daughter choose this home for me and I cannot fault her choice, it is lovely the staff are excellent, the home is beautiful and I have no complaints”.

Care records included information about how people were supported with eating and drinking. People were weighed on a monthly basis or more frequently where they were at risk. Advice had been sought from the person’s GP in relation to weight loss. Where people were at risk of malnutrition, records were kept of their daily food and fluid intake to enable staff to monitor and take action where required. There were gaps in some of the records for people in relation to their food and fluid intake. For example records stated that one person had only one cup of tea in a 24 hour period.

The registered manager told us there was no one presently living in the home that had an acquired pressure wound. Where people were at risk of developing pressure sores a care plan was in place describing how the person should be supported. This included any specialist equipment such as pressure cushions or an air mattress that should be in place minimise any risks. There were also body maps, photographs of healing and information about how staff should support the person with positional changes. Records were maintained of positional changes to enable the staff to monitor the effectiveness of the care delivery. However, we saw there were gaps for some people. This meant people could be at risk of developing a pressure wound as their position had not been regular changed and staff would be unable to ascertain the next position the person should be assisted to.

We found that the registered person had not protected people against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Records, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

People’s health care needs were being met. Where people were funded for nursing care a registered nurse was available 24 hours seven days a week. For those people that were funded for residential care then they were supported by the district nurse team. Staff told us that where referrals had been made to the local district nurse team there was a prompt response usually within 24 hours if not the same day.

People confirmed they could make an appointment with their GP if they required. Staff told us they had access to four local GP practices. Where people lived locally prior to moving to Scarlet House then to ensure continuity they could retain their existing GP. People confirmed they had a choice of GP practices to attend to their health care needs. Staff told us a GP visited every Friday to see their patients and will respond to emergency requests at other times. Records were maintained of health care appointments, including any treatment and follow ups. For example where blood tests had been completed then this was followed up with the GP practice to determine if any treatment was required.

Care records included information on people's physical health needs, for example people had their weight and nutritional needs assessed. Where people had been assessed as being at risk of weight loss a care plan had been put in place. Staff had liaised with a dietician and the person’s GP. Other health and social care professionals were involved in supporting people. They included dieticians, physiotherapists, occupational and speech and language therapists and the mental health team. Their advice had been included in the plan of care and acted upon.

People’s rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting on behalf of adults who lack capacity to make their own decisions. Staff understood how the MCA 2005 protected people using the service and supported them to make their own decisions. They told us they had received training on the MCA as part of their induction and were aware of the principles of the MCA 2005. Staff were aware that where people may lack capacity it was still important to involve them in day to day decisions where they were able. A member of staff said “We



## Is the service effective?

should never assume or do something to someone without fully explaining to them first, it is not about doing, it is about giving people control". This was echoed by other staff we spoke to.

The deputy manager told us best interest meetings were held where people lacked mental capacity and this included seeking the views of the person's relatives and professionals involved in their care such as the GP. Records were maintained of best interest meetings detailing the decision making process and who was involved. An example of this was where a person was regularly refusing their medicines. The outcome was the GP was reviewing the person's medicines to ensure they were easier to swallow. Relatives had been consulted to ensure it was in the person's best interest. Another example was where it was in the person's best interest to take their medicines but they were refusing. It was agreed by the GP, family and the pharmacist this should be given with food in the person's best interest without their knowledge. This is known as medicines being given covertly.

The registered manager had been sending us notifications about people who had an authorisation in connection with the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Where people had been assessed as lacking mental capacity, information was available in their care file about deprivation of liberty safeguards. An assessment had been completed which would indicate an application should be made. The registered manager told us there had been 21 applications made on behalf of people and they were waiting for an independent assessor to meet with the people. These had been kept under review to ensure the least restrictive measures were in place. The registered manager and staff showed a good level of understanding of the process. Policies and procedures were in place guiding staff about the process of DoLS. One person who was subject to an authorisation because of their dementia was supported by staff to go for a walk on a daily basis around the village. This was because it was important to the person and their general wellbeing. The person confirmed they enjoyed their daily walk with staff.

We observed people at lunchtime and saw they enjoyed their meal. The meal was unrushed and relaxed. There was

a choice of two different meals. One person told us, 'The food is very good; we get two choices and if I don't like that they will offer me a further alternative'. Another person told us, "I cannot fault the food, there are snacks available including cake and biscuits, I am never hungry". A member of the catering team told us, "It is important to us, that people are happy and we will go out of our way to accommodate requests for specific meals or snacks". The catering staff were involved in the admission process and would meet with people and their relatives to discuss any specialist diets or likes and dislikes.

All of the staff we spoke with were very knowledgeable about the people they supported. They were able to tell us about people's needs, their likes, dislikes and preferences. They gave a good account of how they supported them. The information staff gave matched what was documented within people's care plans. Staff confirmed they were involved in the care planning process and would sit alongside the registered nurses or team leaders to discuss any changing needs. Staff told us the care plan was always evolving as they were getting to know people and more information was received from relatives or the person themselves. People confirmed the staff would sit with them to discuss their care needs to ensure it was effective and based on their wishes and needs.

Staff told us they had lots of training as part of their induction and this had equipped them with the skills and knowledge to enable them to fulfil their roles in supporting people. Staff completed core training as part of their induction including safeguarding adults, health and safety, basic first aid, infection control, fire, food safety, moving and handling. We were told these were to be updated annually and a plan was in place to ensure that this was staggered for staff so that some would start this earlier to enable every member of staff to receive their annual update. This was because lots of staff had started working in the service during the month of July 2015.

Since the service opened six months ago, staff told us further training had been organised to build on their knowledge since induction. This included training from visiting professionals such as supporting a person with a specific medical condition to eat and drink safely. Other training included end of life care, wound care management, care planning and supporting people with diabetes.

## Is the service effective?

Staff confirmed they received supervision from a senior member of staff. However the frequency varied depending on the staff we spoke with. Supervisions are a process where staff meet on a one to one basis with a line manager to discuss their performance and training needs. Some staff told us they had monthly supervision, another two monthly and the third every six months. It was clear some staff were not aware of the expectations of the organisation. The registered manager told us that supervision with staff should take place a minimum of six times per year. A supervision planner was in place to enable the manager to monitor the frequency of the supervisions taking place. The majority of staff had received supervision at the required frequency.

The registered manager told us all staff would have an annual appraisal but as yet no member of staff had worked for the organisation for a year. A plan was being devised to ensure this would happen with staff being allocated the responsibility to complete these.

Scarlet House was purpose built and decorated and furnished to a high standard. There was clear signage to enable people and their relatives to move around the home. Each unit was decorated using contrasting colour schemes to enable people with dementia to understand where they were. There were memory boxes outside bedroom doors which contained personal items such as photographs or ornaments. This helped people to locate their bedrooms and enabled staff to talk with people about important memories. For example some people had pictures of family and others war medals.

Bedrooms were personalised with people's possessions including furniture, pictures and ornaments. All bedrooms had an ensuite and were decorated to a high standard.

# Is the service caring?

## Our findings

People and relatives told us the staff were kind, friendly and compassionate, all felt they were treated with dignity and respect and their care needs were met. Comments included “(Name of nurse) is wonderful, she is so kind, she will do anything for me, they are all nice and friendly” and “The staff are very helpful, from making a cup of tea at 7:30 in the morning to helping me get dressed, they encourage me to do what I am able and they always ask if there is anything I need”.

One relative told us “It is so lovely here; I can sleep well at night knowing my mum is well cared for”, “I have only seen kindness, they are wonderful”. “As soon as I walked in the door, I knew mum would be happy here” and, “I think mum sees the staff as extended family”.

Some of the people told us they had recently moved to the home. They told us they had settled in well and the staff had been kind in helping them during this time. One person told us “it was a difficult decision to move to a care home, but I have made new friends it is excellent here”. Another person told us “My daughter made the decision for me to move to this home and I cannot fault it, everyone is so friendly, it is beautiful here”.

Staff were observed giving people encouragement when assisting them. For example, one person was being supported to move from one area of the home to another. The member of staff was heard giving gentle encouragement. They were also engaged in a conversation about what activities were taking place that afternoon and general conversation about the person’s expected visitors. It was evident the person was enjoying the conversation and the staff member was knowledgeable about the person.

Another person was being supported by a physiotherapist to mobilise; a member of the house keeping staff was seen to be giving praise and encouragement. The person’s facial expression showed they appreciated the staff’s interaction. The registered manager told us the ethos of the home was that every staff member, irrespective of role, was expected to engage with people living at the service. It was evident staff had got to know people well including their preferences and life histories enabling them to engage in conversation with people.

We observed staff asking people if they would like assistance and their wishes were respected. Where people had refused personal care we observed staff returning later in the morning to offer assistance. This meant people were supported to make day to day choices on when they would like to receive care and these were respected.

Staff described people in a positive way and demonstrated they had a good understanding of how individuals liked to be supported. For example, when people liked to be assisted with personal care or that some people liked a cup of tea at a certain time and how important it was for that person. This level of information was captured in the care plan for example ‘X does not like to be disturbed before 10:30 in the morning’. This care plan clearly described how the staff should communicate with the person and how they would respond to their wishes.

We observed people being supported with lunch. The meal was relaxed and unrushed. Where people required assistance this was done sensitively and at the pace of the person. Staff were observed sitting alongside the person explaining what they were eating and offering encouragement. People were offered cloth aprons to protect their clothes from food spillages. Where people had spilt food on their clothes they were offered to change after lunch. Staff were observed offering assistance in a sensitive and discreet manner. For example people were offered assistance which did not bring attention to them as staff spoke quietly and directly to the person.

People were addressed using their preferred name. Staff confirmed that people were asked what name they would like to be called on admission. This was recorded in the plan of care.

People’s religious and cultural needs were taken into account on admission and during care delivery. The registered manager told us it was important for people to retain their interests taking into account their cultural and religious faiths. Holy communion was offered to people on a monthly basis however if a person wanted to attend church this would be accommodated. Some people were supported to attend the local church’s coffee morning. We were given an example where a person had requested they were visited by their catholic priest and this was organised.

People told us about how they were supported to continue with hobbies and interests such as gardening and baking. A relative told us it was important for their mum to be able to

## Is the service caring?

put their laundry away. They told us this enabled them to retain some independence and control on where their things were put. People told us the staff encouraged them to be as independent as possible with day to day tasks such as personal care and mobility. One person told us "Sometimes it is nice to know that staff are just there in case of an emergency but I can do most things for myself".

People were able to maintain contact with family and friends. In addition to the café which was situated on the ground floor, throughout the home there were quiet seating areas to enable people to entertain their visitors. Each unit had a small kitchenette where people or the

guests could help themselves to tea and coffee. People had access to a telephone in their bedroom if they wanted and internet access. The registered manager told us that some people had used the large cinema screen to contact relatives via Skype.

People's wishes were respected about their end of life care. Care files showed people were asked about their end of life care. Relatives provided further information including their contact details and when and if they would like to be contacted. Some staff had completed training in palliative care including specific medicines to ensure people were pain free when receiving this care.

# Is the service responsive?

## Our findings

People told us about a variety of activities that took place at the service and in the local community. Comments included “I enjoy the games, they are so much fun”, “We made flowers the other day, I gave it to my granddaughter, she was very pleased”, “I am never bored” and, “We make things together, I am not good at it but I enjoyed it very much”.

Activities included games afternoons, coffee mornings, bingo, pamper sessions, discussion groups to aid memory, quizzes, baking, gardening and arts and crafts. In addition there was time allocated for one to ones with people who did not like to participate in group activities. There was an activity co-ordinator employed to support people with activities of their choosing either in group sessions or on a one to one basis. The activity co-ordinator told us there were formal activities arranged five days a week. Weekends were less formal with more one to one activities organised by the care staff. The registered manager told us that a further two activity co-ordinators were being employed to ensure there were activities planned seven days a week. Some people had told us the activities were not so well organised at the weekends. Throughout the year there were theme days based on religious and seasonal events and people’s birthdays were celebrated. Relatives and friends were asked to these events.

External entertainers visit the home to provide music events at least a couple of times a month. A hairdresser visits the home twice a week and the local church provides holy communion on a monthly basis. The registered manager told us it was also important for people to continue to be part of the local community. Some people were supported to go to the local church for the weekly coffee morning others, had been supported to go to the local garden centre and trips out. People also told us local school children visited and shared with them their art work.

There was a designated area on the ground floor that had been set out like a coffee shop. People were observed using this area either independently or with staff support and helping themselves to teas and coffees. A selection of cakes and biscuits were available for people and their visitors. A person told us “I meet my granddaughter in the coffee shop, she even brings her friends along sometimes, it’s lovely”. Another person told us “I meet all my visitors

here, I don’t want to meet friends in my bedroom” and a relative told us, “The coffee area is great, mum used to meet her friends in town for coffee, it’s not like visiting a care home”.

In addition to the coffee shop, there was a cinema and a hair dressing salon on the ground floor. A receptionist was based in this area, along with the office staff and the registered manager’s office. We saw the reception staff responding appropriately to the needs of people and their relatives with general enquiries.

People confirmed they did not have to wait long for staff when they used their call bell. Where a call bell had been ringing for more than 6 minutes then this would go into an emergency buzzer to alert staff. If staff had responded to an emergency and required additional staff they could sound the emergency buzzer to call for assistance promptly. We observed call bells being answered in less than three minutes. The registered manager told us they regularly monitor the response to call bells and since opening all calls have been responded too within three minutes.

People had their needs assessed before they moved to the home either by the registered manager or the deputy manager. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. People had a care plan covering all areas of daily living. This included personal care, eating and drinking, sleep, hobbies and interests and any risks associated with their care or medical conditions. The care documentation included how the individual wanted to be supported for example, when they wanted to get up, their likes and dislikes and important people in their life. These were reviewed on a monthly basis. Staff told us the care plans were always evolving as they were getting to know people.

People confirmed their involvement in discussions about their care. Care plans were held electronically with a paper copy being printed off monthly. The previous month’s care plan was destroyed as the audit of changes was recorded electronically. However, this meant the signed copy of the care plan by the person or their representative had been destroyed. This was brought to the attention of the registered manager who said this would be rectified so that they could further evidence people’s involvement and consent to their plan of care.

## Is the service responsive?

People we spoke with confirmed they had been supported well when they had first moved to the service. They said the staff had sat with them to get to know them and were always checking with them whether this was still correct. A member of staff told us, “All our residents are different and we treat them as individuals”. They also said, “People can vary from one day to the next, so we don’t assume that they like the same thing for breakfast every day, we always ask to check what they would like”. This showed that staff were responsive to people’s changing needs and they were involved in decisions about their care and support.

A visiting professional told us “There has been a positive working relationship in supporting people; the staff are proactive in making referrals, willing to try new ideas in supporting people and acting on their advice”. They told us the staff communicated well with each other ensuring important information was shared with the team.

Daily handovers were taking place between staff. Staff told us this was important to ensure all staff were aware of any changes to people’s care needs and to ensure a consistent approach. Staff described how they worked as a team to enable them to respond to people’s needs and stated that communication was an important factor.

Information was made available to people about the service. This included a statement of purpose, a brochure about Scarlet House and what it has to offer including

information about how to raise a complaint. These were available in the main entrance of the service. It was noted that a notice board containing information about a recent resident and relative meeting, planned activities and the menu was not in a prominent place where people could see the information. This was because it was in the corridor by the cinema leading to the kitchen and laundry and not a general walk way for people. The registered manager told us they would explore how this could be more accessible to people. It was also noted that some information was in small print which may make it difficult for some people to read. One person was seen taking a magnifying glass to assist with reading the menu card that was displayed on each dining table. A large font may assist people in this area.

There was a complaints policy and procedure. The policy outlined how people could make a complaint with a timescale of when people could expect their complaint to be addressed. We looked at the complaints log. We found people had been listened to. The records included the nature of the complaint, the investigation and the outcome. We found complaints had been responded to within the agreed timescales. A relative told us they had recently raised a minor concern and they were happy with the outcome and felt this was being addressed, this included an apology.



# Is the service well-led?

## Our findings

Scarlet House opened in September 2014. The registered manager told us admissions to the service were planned with no more than five people moving to the service over a seven day period. This enabled them to plan the care and ensure staff were aware of people's individualised needs. The registered manager told us staffing was reviewed regularly to ensure there were sufficient staff to support the new people without compromising the care and safety of the existing group. The registered manager told us this had been agreed with the senior management of Care UK. This showed the registered manager had a good understanding of opening a new service and wanted to get it right for people. The registered manager told us she was well supported by the senior management group and a representative visited once a month to monitor the quality of the service.

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a nurse and a senior care worker on duty to guide the care staff. The registered manager was supported by a deputy manager. Staff had signed contracts in their files along with job descriptions on what was expected of them.

Daily management meetings took place with the heads of departments. This included the nurse and senior care lead, the cook, head of housekeeping, the deputy and registered manager. The purpose was to discuss any known risks in the service, new admissions and staffing arrangements and how best to manage them. This information was then cascaded to the team.

Staff spoke positively about the leadership of the home and the culture of putting people first. All staff we spoke with described their commitment to providing individualised care with people being encouraged to participate in making decisions about how they would like to be supported. Staff told us that information was shared with them about people during handover.

Some staff told us they felt they were still developing as a team and this was continually being built on. They explained that many of the staff had worked in different care settings and it was taking time for the team to be established. All staff confirmed they had received a comprehensive induction and were supported by senior staff, including the manager, the deputy manager, team

leaders and the registered nurses. The registered manager was proactive in developing the team as a whole and for each unit. Meetings were held with staff every two months with minutes kept to enable those that had not attended to be kept informed. Discussions included sharing information about the running of the service and the care of people. It was evident that staff meetings were used to discuss and share information as part of ongoing training for staff. Topics included safeguarding adults, principles of the mental capacity act and the role of the Care Quality Commission in regulating health and social care.

Staff confirmed they could approach the registered manager with any concerns or to make suggestions. The registered manager had an 'open door' approach to managing the service enabling staff, people and their visitors to make contact with her. The registered manager's office was situated near the main entrance. People and their relatives were seen making contact with the manager. Meetings had been organised for people and their relatives. The registered manager told us two meetings had been cancelled due to planned activities taking place in the service and a trip to a local garden centre, but the plan was for these to happen bi-monthly. The registered manager told us these would be kept under review as more people moved to the home. The registered manager envisaged that as more people moved to the home then there may be a need for two separate meetings taking place, one on the ground and one on the first floor. People's views had been sought in relation to the running of the service. People were kept informed of the occupancy rate and information about staff recruitment. The manager told us the cook had spent time speaking with people about the quality of the food and as a consequence changes had been made to the menu. The cook confirmed this stating "We just want to get it right for people".

The registered manager told us in response to some concerns about access to the home outside of office hours, a receptionist now worked up to 18:00 including weekends. This was because on occasions visitors were concerned about the length of time the staff had taken to answer the door. The registered manager was also planning to link the doorbell to the call bell system to alert staff there was a visitor enabling them to respond quicker.

Systems were in place to review the quality of the service. These were completed by either the registered manager or a named member of staff. They included health and safety,

## Is the service well-led?

medicines, care planning, training, supervisions, appraisals and infection control. The registered manager told us they received electronic alerts where care plans had not been reviewed or a daily diary for a person had not been completed in a six hour period. The provider completed checks on the service detailing areas for improvement. This included a review of people's care records with any actions required for example some care plans made broad statements such as the term 'regularly'. This meant it was open to staff interpretation and would mean the care plan would be difficult to review and monitor. The registered manager told us training on care planning was being cascaded to the team and improvements in this area had been noted.

The registered manager completed checks on accidents and incident reports to ensure appropriate action had been taken to reduce any further risks to people. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Incident reports were produced by staff and reviewed by the registered manager. The registered manager was able to produce a report on the incidents that had occurred including any action they had taken to reduce the risks of the incident reoccurring. This included looking at any themes.

From looking at the accident and incident reports we found the registered manager was reporting to us appropriately. A notification is information about important events which the provider is required to tell us about by law.



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

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**How the regulation was not being met:** People who use services and others were not protected against the risks associated with unsafe or inappropriate care and treatment. This was because of incomplete records being maintained in respect of food and fluid and positional charts. Regulation 17 (2) (d).

### Regulated activity

Accommodation for persons who require nursing or personal care  
Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**How the regulation was not being met:** People who use services and others were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12 (2) (f).