Care Quality Commission

Runwood Homes Limited

Tallis House

Inspection report

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Ratings

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

Overall summary

This inspection too place on 26 November 2014 and was unannounced.

On our previous inspection in July 2014, we had concerns about how the service supported staff and with record keeping. The service sent us an action plan detailing how they would be addressing these issues. This inspection found that improvements had been made in these areas.

The service is registered to provide care and accommodation for up to 101 people. There were 98 people living at the service on the day of our inspection. The accommodation is arranged into three units spread over three floors.

The service had a registered manager in place. 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 was safe. Staff were trained to recognise signs of abuse and knew what to do if they suspected abuse. Where people raised concerns about their care and support the service took appropriate action to deal with these. Relatives and/or people's representatives were consulted where necessary.

Summary of findings

The service ensured there were sufficient adequately trained staff to available to provide effective care and to meet people's needs. However some staff were overdue with refresher training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with could not tell us how they worked within the principles of the MCA.

The community nursing team were working with the service to reduce the number of hospital admissions by improving care plans and staff knowledge of conditions such as diabetes.

Throughout our visit we observed caring and supportive relationships between people and care staff. People were treated in a caring way that demonstrated a positive caring culture existed in the service.

The service provided group activities for people. However, these were not always tailored to an individual's needs. We noted that two people were not supported to continue taking part in religious observance as they had prior to moving into the service.

The service demonstrated an open culture with people and staff able to discuss any problems with management. The registered manager was supported by the provider with regular visits from the provider's representative.

The service had quality assurance systems in place. The providers representative visited the service regularly to carry out their own audits and monitor the quality of care provided.

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?
The service was safe.

People who used the service were safe because there were systems in place to make sure they were protected from abuse and avoidable harm.

Staff had received training in how to recognise and report abuse. All knew how to report abuse and told us they would do so if the need arose.

There were sufficient suitable trained staff to provide safe and effective care.

Medicines were administered safely.

Good

Is the service effective?
The service was not always effective.

Staff had received training the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, some refresher training was overdue and not all staff had understood the training.

Staff received a thorough induction before providing care.

People were supported to have a good diet.

Requires Improvement

Is the service caring?
The service was caring.

People were supported by staff who were kind, caring and respectful of their right to privacy.

We saw that staff showed patience and understanding when interacting with

people who used the service.

People were able to make choices about their day to day lives.

Good

Is the service responsive?
The service was not always responsive.

People were provided with group activities. However, people were not supported to maintain interests and hobbies they had enjoyed before moving into the service.

The service recorded people's life histories but these were did not contain sufficient detail for staff to use when supporting people with reminiscence.

Requires Improvement

Is the service well-led?
The service was well-led.

Good

Summary of findings

Senior staff and managers were visible in the service providing a positive role model.

The manager received support from the provider to manage the service.

Quality assurance systems were in place.

Tallis 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.

The inspection took place on 26 November 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert on this inspection had experience of dementia services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked the information that we held about the service and the service provider.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spoke with the seven people who were living in the service, five relatives, six care staff and the cook. The provider's regional care director visited the service during our inspection and spoke with us about the providers quality assurance processes. We also spoke with a member of the community nursing team. We spent time with people in the communal areas observing daily life including the care and support being delivered.

We looked at four people's care records as well as records relating to the management of the service. We looked round the building and saw some people's bedrooms (with their permission), bathrooms and communal areas.

As some of the people who live in the service live with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe and were happy living in the service. Staff told us they had received training on how to recognise abuse and told us how they would report abuse. One member of care staff told us that safeguarding is always discussed at care team meetings.

One person gave us an example of a problem they had encountered with another person coming uninvited into their room. They explained that they had raised this with care staff and that options for dealing with the problem had been discussed with their relatives and care staff. They told us about the measures that had been put in place to prevent the problem re-occurring and that now they felt safe. This demonstrated the service putting into practice positive actions when dealing with a difficult situation that could potentially cause harm.

Risks to people's safety had been assessed. People had been involved in the assessment and that this was reviewed regularly. Individual risk assessments with action plans had been provided for staff with information which described how to manage risks safely when supporting people. For example, with safe moving and handling techniques and how to react positively when someone may present with a distressed reaction to a situation or another person. This enabled staff to provide care to people safely whilst supporting them to retain as much independence as possible.

We saw that a person had bruising to their face. They were unable to explain to us how the bruising had occurred. We spoke with staff and checked the service records for an explanation of what had happened. Staff were able to explain the incident to us and we saw that it had been documented in the person's care plan and recorded in the accident book. The service had followed it's risk management policy. Measures had been put in place to reduce future risks to the person. Consideration had been given to using the least restrictive option to keep this person safe.

The service used a dependency assessment tool to assess people's needs to determine the number of staff required to provide people with the care and support they needed. The registered manager told us that they had a bank of staff to use when required such as when staff were on annual leave or sickness absence.

People we spoke with said that staff were available to support them when needed and that call bells were answered promptly. Two people said that staff had time to sit and talk with them during the day.

Medicines were stored securely in locked rooms. Access to these rooms was restricted to senior staff to avoid distraction to staff when dealing with medicines and to reduce access for security reasons.

We noted that creams were not kept in the medication rooms but in people's rooms. We saw that these were left on top of people's cabinets. Some creams were prescription medication and were not being stored securely.

Staff told us that the service had recently changed the supplier and systems for the administration of medication. They told us they received training in the new system and had been assessed as competent. All of the staff we spoke with felt that the new system was an improvement on the previous one and that it reduced the risk of errors occurring. Regular audits of medication in stock were carried out by senior staff.

Requires Improvement

Is the service effective?

Our findings

People told us that they were able to make choices about how they received support from care staff. One person said, "They say to me, 'do you want to go to bed now or later?'"

All of the care staff we spoke with had received an induction which included shadowing an experienced member of staff. All staff received regular supervision sessions from their line manager. This included a bank worker who worked as and when needed. They told us that this equipped them with the knowledge and skills required to deliver care effectively.

We saw that people were able to move around the service as they wanted. One person told us, "I am not restricted in any way." Staff we spoke with told us they had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, when we asked staff to give us an example of when the MCA applied they were unable to do this. One person had only recently carried out the training but could not remember anything about it. Another person told us it was about ensuring people got choices. We checked the service training records. We saw that one senior member of staff and 11 care staff were overdue refresher training in MCA and Dols. If care staff do not have an understanding of the MCA and the DoLS the care they provide may not be within the principles of the MCA. For example they would not know when to refer to others more suitably placed to make decisions when people lacked capacity.

We saw some people were eating breakfast at 10.40am. We asked people about this and they told us this was because they chose to get up and have their breakfast at this time. The service was providing meals at times to meet people's personal preference.

We asked four people about the meals they received. Two people told us the food was good, one saying, "I love the food." Another person described the food as adequate and another as reasonable. We observed the lunch time meal in two of the dining rooms. The food served was hot and well presented. The service asks people regularly about the standard of catering and we saw that action had been taken as a result of the surveys. For instance a change in the menu.

There were sufficient staff available to support people who needed assistance eating their meal. We observed that where a person did not want either of the main courses on offer they were provided with alternatives. We also observed a choice of drinks being provided throughout the day.

Care plans contained dietary assessments and associated care plans. The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is a recognised method to assess people's nutritional state. As part of this screening people were weighed monthly and action taken to support people who had been assessed as at risk of malnutrition.

People told us that they were visited by health care professionals as needed. They gave us examples of visits to the optician, general practitioner and dentist. One person said that care staff had accompanied them to hospital. Another person told us that they had organised their own dentist appointment but that a member of care staff had gone with them. Relatives and visitors we spoke with were confident the service would make referrals when required. One person said, "I think they are on the ball for spotting things."

The service was working with the community nursing team to ensure care plans reflected the needs of people with complex health conditions. This was intended to prevent future hospital admissions. We spoke with a member of the team who was visiting the service on the day of our inspection. They told us that they felt the service was generally performing well and that they were delivering training to staff which supported with people with complex needs.

People felt that care staff had the skills needed to support them with their needs. One person told us, "Most of them have. New ones, they're learning and they are very good." A relative said they felt that carers had knowledge of their relative's needs which they had demonstrated by the updates that carers gave her.

Good

Is the service caring?

Our findings

People we spoke with said they were happy living in the service. They told us they got on well with staff and all had positive things to say about staff. For example one person told us, “They are helpful. We have a laugh and joke together.” Another person told us, “I’m very friendly with staff.”

Staff we spoke with told us there was sufficient time for them to develop relationships. One staff member told us, “We do get time to talk to people. I regularly get time to sit and have a chat.” We observed staff providing care in a friendly and supportive manner. We saw one person living with dementia being assisted by a member of staff to choose what jewellery to wear that day.

People were supported to express their views and had been actively involved in making decisions about their care, treatment and support. Care plans reflected people’s wishes, choices and preferences. One relative gave us an example when their relative living in the service had refused to have a bath and that staff had respected that decision. Another relative told us that the service had involved them in a review of a person’s care plan when they had returned from hospital.

Each person living in the service had one member of care staff allocated as their key worker. The key worker acted as a consistent point of contact for people and their family. The key worker carried out the regular review of the care plan with the person and their family if appropriate. People told us that they knew their key worker well. Staff told us that the scheme worked well enabling them to get to know individual people and to give them information and explanations they may want regarding their care. They told us that this was particularly important for people living with dementia as they got to know there likes and preferences and could remind them of these if their memory failed.

People told us that their dignity was privacy were respected. One person told us that staff, “knock on my door before they come in.” Staff we spoke with were able to give an explanation of how they ensured that people’s privacy and dignity were maintained whilst providing personal care. One member of staff told us, “Always explain what you are doing and offer choice where you can. For example, you can ask if they wish to do certain tasks for themselves if they are able and offer them choices of different clothes to wear. But basically chat to them and treat them like a person, not a series of tasks.” This demonstrated that staff had a good understanding of how to respect people’s privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to carry on with activities that they had participated in before moving into the service. For example we saw in two people's care plans that before moving into the service they had been extensively involved with their respective local church. We asked one of the people if they were able to participate in church services now. They told us, "No, I have to watch Songs of Praise on my television." We were not able to speak with the other person however records did not show that they had been involved in any religious activities. Another person told us they would like more speakers and entertainment. They told us they would like to see somebody from the church more as they now had to pray on their own. The service was not responding to the religious needs of these people.

Another person told us how they had previously liked to read a lot but due to a deterioration of their condition they were no longer able to do this. We did not see any specialist equipment in this person's room such as specialist magnifying equipment or talking book facilities to enable them to carry on with this activity. This had not been identified by care staff and this person was not able to continue reading which they had previously enjoyed.

We spoke with a person living with a physical a disability. They told us that they had not been able to go out on a recent trip as the mini bus had not been able to accommodate their wheelchair. They also told us that before moving into the service they had been a member of a local society but that since moving into the service continued attendance had not been possible. This meant that they did not now see people they had previously socialised with and that they had become isolated from the wider community they had socialised with.

This was a a breach of Regulation 9 (b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's care plans contained an assessment of their needs. We saw that, where possible, people had been involved with this assessment of their care needs. Where concerns were identified as a result of the assessment care plans specific to this were put in place. For example where people were at risk of developing pressure sores or falls.

Care plans we looked at contained life histories of people. However, these were lacking in detail. Recording a person's life history and previous interests and aspirations in more detail would give staff more insight into that person particularly when, due to their living with dementia, a person's memory may be impaired.

On the day of our inspection we saw that in one lounge singing and dancing was taking place led by the activities coordinator. Short positive interactions took place between people and care staff. In another lounge we observed a person completing a word search and others looking at magazines. This type of group activity supported people with social engagement.

People we spoke with told us they knew how to complain. One person told us, "If I've got any query I just go to the office." We looked at the service complaints record and saw that these were recorded and investigated in accordance with the provider's policy. The registered manager monitored complaints to see if there was theme which needed to be addressed for example changes to the labelling of clothing.

Good

Is the service well-led?

Our findings

People said that they found the manager and staff approachable. We noted that staff were positive and supportive when providing care to people. One person told us, “You can talk to them. I talk to them.”

We saw that the service held regular staff meetings for different designations of staff. For example domestic staff, care staff and senior staff. There were minutes of the meetings available in the staff room. However, minutes we viewed did not show that actions arising from these meetings were followed through to a conclusion. We discussed this with the manager who told us that actions were taken as a result and that they would amend future recording of meetings to reflect this.

Staff told us that they had regular supervisions from their line manager and that these were informative and constructive. They told us that good work and any areas for improvement were discussed at their supervision session. This meant that staff received feedback from managers in a constructive and motivating way. All the staff we spoke with were enthusiastic and well-motivated to provide good care.

The management team were visible throughout the service. Everybody we spoke with knew who the registered manager was and some knew who the area manager was. Staff we spoke with felt there was good leadership in the service both from the registered manager and from senior care staff. One person told us, “I’ve worked in lots of care homes and this is the best one.”

The registered manager was supported by a regional care manager who visited the service regularly. The regional care manager carried out inspections of the service in order to identify any areas for improvement. Action plans were developed from these inspections and additional resources provided if required. The registered manager told us that they attended manager’s meetings organised by the provider which were an opportunity for learning and to exchange good practice.

The manager carried out regular audits within the service. These included medication, the number of falls and complaints received. The provider monitored these audits. Where trends were identified either by the registered manager or the provider actions were put in place to ensure improvement. An example of action taken was the recruitment of a new cook after audits and surveys had identified an issue with the preparation of food at certain times of day.

The provider monitored risks across its services. We saw that the registered manager provided the result of audits to the provider on a weekly and monthly basis. These included falls, pressure ulcers and the results of nutrition screening. If the provider identified a trend in a particular aspect of care we saw that an action plan was put in place which was monitored by senior staff.

Relatives told us they were aware of relatives meetings and had received questionnaires about the care their relative received. Although one person did say that meetings were a bit late to attend they were aware that the minutes from these meetings were posted on a board in reception.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not meeting the needs of the individual person.