Care Quality Commission

Veecare Ltd

Tralee Rest Home

Inspection report

38-40 Tankerton Road
Whitstable
Kent
CT5 2AB
Tel: 01227 276307
Website: www.traleeresthome.co.uk

Date of inspection visit: 29 January 2015
Date of publication: 23/04/2015

Ratings

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

Overall summary

The inspection visit was carried out on 29 January 2015 and was unannounced. The previous inspection was carried out on 13 & 17 December 2013, and no breaches were found with the regulations.

Tralee Rest Home provides accommodation and personal care for up to 36 older people living with dementia. The service was providing accommodation for up to 34 older people at the time of the inspection, as two of the bedrooms could be shared by two people, but were being used as single rooms.

Accommodation is provided on two floors, with access to the first floor via a passenger lift. The premises include an original old building, with a large purpose-built extension. The service is situated in a residential area of Whitstable, near to the town and the beach.

The service is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and DoLS. No-one living at the home was currently subject to a DoLS authorisation, but the registered manager had discussed when to make applications with the lead person for the local authority DoLS team, and was following their advice.

The service had suitable processes in place to protect people from different types of abuse. All of the staff had been trained in safeguarding people and in the service's whistleblowing policy. (Whistleblowing enables staff to raise matters of concern about other staff in an unbiased way, and without fear of discrimination). Staff were confident that they could raise any matters of concern with the registered manager or with the local authority safeguarding team.

The service did not meet the requirements for maintaining effective infection control procedures. There was a lack of liquid soap and paper towels available in communal toilets and bathrooms; and a lack of foot operated pedal bins for used paper towels. The floor and walls in the laundry area included exposed brickwork and floor tiling, which did not provide a continuous surface which could be easily cleaned. There were no separate hand washing facilities in the laundry. This presented an infection control hazard. The registered manager was not familiar with the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance' and did not have a copy of this document. (The Code of Practice sets out the requirements for regulated services to meet the regulation for cleanliness and infection control).

The service had procedures in place to maintain the environment and equipment in good working order. Regular checks were carried out for equipment such as mobile hoists, bath hoists, fire alarm systems, fire doors, nurse call system and emergency lighting. However, there was a lack of arrangements and equipment to move people with restricted mobility out of first floor rooms in the event of an emergency.

The registered manager had systems in place to record accidents and incidents, and to monitor these to see if there were any patterns of occurrence, such as the same time of day, or the same staff on duty. Records showed that these were analysed to assess if any action could be taken to avoid further accidents, and identified action was taken in response.

Care staff were evident throughout the service during our inspection visit, offering support to people who were walking about or sitting in their rooms or communal areas. Relatives said that the registered manager and staff were always easily available. The registered manager was recruiting for two posts in care and for an activities co-ordinator. The service employed staff from an agency to ensure sufficient numbers of care staff were on duty, if existing staff were unable to carry out additional shifts. The registered manager always asked existing staff first, as this provided continuity of care for people living with dementia.

The service had reliable staff recruitment procedures in place. Applicants were assessed as suitable for their job roles, and new staff were provided with a detailed induction programme, which included training in essential subjects. Refresher training was provided at regular intervals.

Medicines management was overseen by the registered manager, who carried out arrangements for repeat prescriptions and receipt of medicines into the home. Only senior staff who had completed training and been assessed for their competency were permitted to administer medicines.

Staff were supported through daily handovers between shifts, staff meetings, individual supervision sessions and yearly appraisals. They were able to develop their knowledge and skills through further training courses, and formal qualifications. Staff demonstrated their understanding of the Mental Capacity Act 2005 and how to apply this, by encouraging people to make individual choices about their daily lifestyles, and respecting their decisions. This included choices such as where they wanted to sit, what they wanted to wear, and what they wanted to eat.

People said they enjoyed the food. The menus showed there was a wide variety, providing a nutritional diet.

Summary of findings

Food was attractively presented. People were encouraged to eat together at dining tables, so as to provide social inclusion and the enjoyment of interacting with other people at meal times.

Staff had a friendly and caring approach to people, and it was pleasant to hear their kind words of encouragement, and to view their patience in caring for people. They did not rush people for responses, but listened quietly and gave people time to respond to questions.

People and their relatives were involved in their care planning, depending on the wish of the person receiving care, and their ability to understand the information. Care plans showed that their health needs were assessed, and were monitored accordingly. A GP visited the service each week, or more frequently if the need arose.

People did not have access to a sufficient range of activities at the time of our inspection. This was partly due to on-going recruitment for an activities co-ordinator. There was a range of games and activities available in a small lounge at the front of the premises, but there was little evidence that people were actively offered the opportunity to take part in these during the day. There was a lack of sensory items for people living with dementia to enjoy; and access to the garden was limited to people who had sufficient mobility to manage steps down to the lawn. This did not ensure the welfare of people living in the service.

People and visitors were supported in voicing their feelings, their concerns, and complaints. The complaints procedure included information and contact details for the registered manager, the regional manager, and other organisations, including CQC. A monthly complaints log was sent to the head office so that the company could monitor complaints and check they were being followed through appropriately.

The registered manager had a daily visible presence in the home and led the staff in caring for people. Senior care staff were on duty for each shift to assist the registered manager with oversight of the staff, and support them in providing effective care. Staff said that the registered manager was very approachable and listened to their views.

The registered manager carried out a range of monthly audits to assess and monitor the progress of the home. These identified shortfalls in the service and action was taken in accordance with the findings. However, the infection control auditing process was incomplete, and had not identified and addressed the issues which compromised effective infection control in different areas of the service. Health and safety audits had failed to show that there was a lack of suitable equipment in an emergency to assist people with restricted mobility to move from rooms on the first floor.

People and their relatives knew that the registered manager had an open door policy, and that they could talk with her whenever they wished to. Their feedback was obtained through daily conversations, phone calls and e-mails, and through the use of yearly surveys carried out by the provider. Yearly questionnaires were also sent out to visiting health professionals; and questionnaires were given out to people living at the service every three months. This provided them with a regular opportunity to raise any concerns about the service. People's comments were used to bring about change and on-going improvements to the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of 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?

Requires improvement

The service was not always safe. Infection control procedures were not always followed and this put people at risk of infection. There was a lack of suitable arrangements and equipment to move people with restricted mobility from first floor rooms in the event of an emergency.

Staff understood procedures for safeguarding adults, and how to raise concerns.

Environmental risk assessments and individual risk assessments were in place for people's protection. Staffing numbers were suitable to provide people with effective care.

Medicines were managed safely. The registered manager carried out checks for medicines management.

Is the service effective?

Good

The service was effective. Staff had received training in subjects that were relevant to the people in their care, and were kept up to date with any changes in practice.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005. Where people lacked the mental capacity to make decisions staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

The service provided a range of food and drinks for people to have choice and a nutritious diet. Staff supported people to eat and drink sufficient amounts to maintain their health.

Is the service caring?

Good

The service was caring. Staff treated people with respect and kindness, and treated them with patient understanding.

The service provided people and their relatives with on-going information about their health and care needs; and arranged advocacy services if these were required.

People were encouraged to retain their independence and staff maintained their privacy and dignity. Staff delivered compassionate and sensitive care when people were at the end of their lives.

Is the service responsive?

Requires improvement

The service was not consistently responsive. The service did not provide sufficient daily stimulation and activities for people living with dementia.

Summary of findings

Care planning identified people's physical and emotional needs and enabled staff to give people individualised care.

The service had processes in place to listen to people's concerns and complaints and responded to these appropriately.

Is the service well-led?

The service was not consistently well-led. Auditing procedures had failed to identify unsuitable practices in regards to infection control; and a lack of equipment in the event of an emergency. Policies and procedures did not accurately reflect practices in the service.

The registered manager was available to people on a daily basis, and kept up to date with people's views, concerns, and individual health needs.

The registered manager led the staff in providing co-ordinated team work, and in ensuring that staff understood their responsibilities and carried them out correctly.

Requires improvement

Tralee Rest Home

Detailed findings

Background to this inspection

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

The inspection took place on 29 January 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the provider is required to tell us about by law. We reviewed information sent to us by members of the public who wished to share their views. We spoke with one health professional on the day of our inspection visit, who gave us permission to quote their views of the service in our report. We contacted one other health professional after the inspection to obtain their views.

During the inspection we carried out an observation for one hour in the morning, called a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We viewed all communal areas of the service, and some people's bedrooms. We observed staff interactions with people throughout the inspection. We talked with six people who were living at the service, and three relatives and friends. Conversations took place with individual people in their own rooms, and with people together in the lounge and dining areas. We talked with six staff, including care staff, domestic, laundry and catering staff. The registered manager was present throughout the day.

During the inspection visit we reviewed a variety of documents. These included five people's care plans, four staff recruitment files, the staff induction and training programmes, staffing rotas for two weeks, menus, medicine administration records, equipment servicing records, environmental risk assessments, quality assurance questionnaires, minutes for staff meetings, auditing records, and some of the home's policies and procedures.

Requires improvement

Is the service safe?

Our findings

People said they were happy living in the home, and one person said "I am very settled here". Another person said "Thank you for looking after me so well", to a member of staff, and told us, "They are very good to me".

Staff did not follow suitable infection control procedures. We looked at toilets, bathrooms and the laundry room as well as some bedrooms and communal areas of the home. Some of the communal toilets and bathrooms did not have liquid soap, paper towels or foot-operated pedal bins for used paper towels. In one bathroom the toilet seat was damaged, and the base of the hoist was chipped and rusty meaning that neither could be properly cleaned. One bathroom had a cleaning mop left in cold water in a bucket. Mops should always be removed from water and allowed to dry out when not in use, as they can harbour bacteria. The service did not have a sluice room although several of the people living at the service used commodes in their bedrooms. The manager told us that staff emptied commodes down toilets, but there was no equipment for commodes to be effectively cleaned after emptying. Staff used a bath for this purpose, in a bathroom that was no longer used for people who were living there.

The service had either one or two domestic staff on duty each day to clean a large building. The service cared for people living with dementia, some of whom had difficulties with urinary incontinence. Carpets required daily cleaning in some areas because of people's incontinence. Six bedrooms per day were cleaned thoroughly, but other bedrooms had minimum tasks carried out such as emptying waste bins and cleaning toilets and wash basins, because the domestic staff were too busy to clean every room thoroughly every day.

The laundry room did not have a separate sink for hand washing. The wall behind the sink was discoloured and the surface could not easily be cleaned. The walls were exposed brick work and could not be effectively washed down. The floor was tiled and therefore did not provide a continuous surface for cleaning. This presented an infection control hazard. The laundry staff used red alginate bags for dealing with soiled or infectious items of clothing or bed linen. This method ensures that these do not come into contact with other laundry items. Care staff and laundry staff used personal protective equipment such as disposable gloves and aprons when giving care or managing laundry.

The service had a hoist and a stand aid hoist, which are types of equipment to assist people with reduced mobility to move from one place to another. The manager told us that at the time of our visit, four people living at the service used the stand aid hoist. There was only one sling for the stand aid hoist, so it was used for several people every day. The infection control policy did not indicate when the item was to be washed and there was no spare sling whilst it was being laundered.

There were 12 policies in place regarding different aspects of infection control practices. None of these explained how commodes were to be cleaned or with what products. The policies did not give specific details about cleaning equipment other than the deep cleaning policy, but this did not state when deep cleaning should be carried out. The registered manager was not familiar with the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance' and did not have a copy of this document. (The Code of Practice sets out the requirements for regulated services to meet the regulation for cleanliness and infection control).

The lack of effective and safe infection control practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Plans were in place for responding to emergencies, such as if there was a fire on the premises. Personal Emergency Evacuation Plans (known as 'PEEPs') were used to show people's individual mobility requirements. However, four people with bedrooms on the first floor could not safely use the stairs. Evacuation plans had been drawn up for each individual but no equipment had been provided to safely evacuate these people downstairs and out of the building. The registered manager said that a wheelchair would be used with two staff to help these people down the stairs. After discussion, the registered manager said that she would contact the fire safety officer and the provider to discuss and obtain more suitable equipment for assisting people down the stairs in an emergency.

This was a breach of Regulation 9 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires improvement

Is the service safe?

Staff demonstrated a good understanding of different forms of abuse, and how any suspicions of abuse should be reported. They were trained in safeguarding adults, and knew about the service's whistle-blowing policy. This enables staff to raise concerns about other staff without fear of discrimination, if the concerns are raised in good faith. Staff were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so. The registered manager kept a printed copy of local multi-agency safeguarding procedures for staff to refer to if needed.

The service did not store any money on behalf of people who lived there. This ensured that their money was protected through individual arrangements with their own relatives or authorised representatives.

People's care plans contained a variety of risk assessments, including those for prevention of pressure sores, risk of falls, and risk of malnutrition. Moving and handling risk assessments identified if people needed equipment and staff to help them with their mobility. Falls risk assessments included how to avoid falls, such as ensuring people were wearing well-fitting shoes, and did not have trip hazards in their rooms. Care plans showed if people were able to use a call bell to request help. Hourly checks were carried out day and night for people who could not use a call bell, or more frequent checks if these were required. People could move around the home freely and external doors had codes to ensure people could not leave the property without staff or relatives to support them.

Equipment such as mobile hoists, bath hoists, fire alarm systems, fire doors, nurse call system and emergency lighting had regular checks carried out. Equipment was labelled to show when it had been tested and serviced. The checks were current and within date. Other checks for people's health and safety included checks for water temperatures, portable appliance testing ('PAT') for electrical items, and a yearly gas safety check. Thermostats were in place for hot water taps and radiators to ensure they stayed within the regulatory limits. Window restrictors had been fitted to windows for people's protection. Radiators were all fitted with radiator covers to prevent scalding.

There were processes in place to monitor accidents and incidents. These were recorded by staff, and reviewed by the registered manager. She carried out a monthly audit which showed if there were any patterns in place, and if action could be taken to prevent further accidents.

Staff were visible throughout our inspection in all areas, and they responded promptly when people needed assistance. Staff told us that they had sufficient staff on each shift to care for people safely, but they said it was not always possible to run group activities for people. The service had a vacant post for an activities coordinator. The levels of staff were not reduced at weekends and levels of staff were adjusted to meet the needs of the people living at the service. Day shifts included five care staff in the mornings, four in the afternoons and evenings, and three at night. Senior staff told us that they tried to provide continuity of care by allocating staff to the same group of people when staff were working consecutive shifts. Staff worked additional shifts to cover leave and sickness, and agency staff were employed when necessary.

The service had reliable staff recruitment procedures in place. Staff recruitment files confirmed that required checks were carried out before staff commenced employment, to assess their suitability for their roles. These included Disclosure and Barring Service (DBS) checks, and checking people's proof of identity. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people). Written references were obtained, and interview records were completed. New staff carried out an induction programme, which included essential training. They were assessed for their understanding and competency before being allowed to work on their own.

Only senior staff who had completed medicines' training were permitted to administer medicines. The medicines were stored in a locked medicines trolley and locked cupboards in a locked room. External medicines were kept separate from internal medicines as part of safe storage procedures. The registered manager carried out ordering processes, and medicines were checked on arrival from the pharmacy to ensure they were correct. There were reliable systems for stock control, and for stock rotation. Some medicines were correctly stored in a medicines fridge, and the temperature of this was checked and recorded daily. A wall thermometer was in place to check the room temperature, but this had not been recorded. The manager

Requires improvement

Is the service safe?

put processes in place on the day of the inspection to keep records of the room temperatures in the future, to show that medicines were being stored at the required temperatures to prevent deterioration.

A controlled drugs cupboard which met regulatory requirements was used to store these medicines safely, and records were well maintained. Medicines administration records (MAR charts) included a photograph of each person to ensure medicines were given to the correct person. Any allergies were highlighted, and MAR charts included clear directions. The charts were accurately completed and there were no gaps in signatures, showing reliable processes for medicines' administration.

Good

Is the service effective?

Our findings

During the inspection we observed positive interactions between staff and people living at the service. Staff reacted swiftly to requests for help, and were observant and quick to help people who were unable to express themselves, or ask for help. A relative told us, "Staff have been fantastic and give amazing care." They told us how their family member had been supported by visits from district nurses to provide specialist equipment and medicines for the person's comfort and pain relief.

People told us that the food was "Very good". We heard one person say to a staff member, "It is lovely of you to give me such a good dinner, thank you". Another person thanked a staff member for sitting with her while she had a warm drink. She said "You have cheered me up".

All the people receiving care and support were living with dementia. The staff had received training in dementia to a basic level, and some had received more advanced training. This enabled them to relate to people, to understand how to support them, and to notice when people needed extra attention. We observed staff interacting with people who had varying levels of capacity to communicate clearly. Staff adjusted their language and approach to suit each individual person. A health professional told us, "The staff are very respectful, but know that some people love a 'bit of banter' and are good at providing lots of positive interaction".

Staff told us that they had received a detailed induction and received training relevant to their roles. The induction training for care staff included the nationally recognised Skills for Care 'Common Induction Standards'. These are the standards people working in adult social care need to meet before they can safely work unsupervised. Staff training records confirmed that staff had received essential training such as fire safety, food hygiene, health and safety, moving and handling, first aid, safeguarding adults, dementia care, and care of people with behaviour that may challenge others. Staff had also received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Training records showed that staff were given regular updates with these subjects.

Staff told us that they had individual supervision with the manager every two months, when they could ask any questions. Care staff were supported by senior care staff who had additional training and experience. The registered manager had put supervision processes in place, so that staff knew when this was due and could plan for it. Staff received updates at handovers between shifts, and said there were staff meetings. These included meetings every three months for senior care staff, and meetings for night staff, so that they were appropriately supported. The registered manager said that they "Talked things through constantly with staff" as it was "More productive to talk on a daily basis than to have lots of meetings".

Staff confirmed they had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), and were able to talk about how they supported people who lacked mental capacity. The Mental Capacity Act 2005 sets out how to act to support people who do not have capacity to make a specific decision. Some people had fluctuating capacity, and were able to make decisions more easily at some times than at others. People or their relatives were asked for their consent for specific reasons, such as flu vaccinations, taking photographs for identity purposes, and for having their medicines administered. Staff ensured that people who lacked mental capacity were supported by their next of kin or representative, and by health and social care professionals, to make difficult decisions on their behalf and in their best interests.

The service had a restraint policy, but staff had not been trained in the use of restraint. They said that they did not use restraint techniques. We observed two people exhibiting behaviour that challenged others, who became verbally and physically aggressive to each other. Staff used effective techniques to diffuse the situation, by swiftly intervening to distract and calm both people down. People who might show aggressive behaviour towards others had risk assessments and care plans in place, and these included directions for staff. For example, one risk assessment stated, "Try to build a rapport and gain the person's trust. Reassure them and include them in what you are doing and why. Give lots of encouragement".

Staff offered people choice throughout the day, for example, where they wanted to go, where they wanted to sit, or what they would like to eat or drink. Some people were given a variety of choice, for example, when choosing

Good

Is the service effective?

drinks, as they could understand the range of drinks offered to them. Other people were given the choice of just two drinks as this was within their mental capacity to make a choice.

The registered manager understood her responsibilities in regards to DoLS. These safeguards protect the rights of people by ensuring that 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. The registered manager told us she had been in discussion with the local authority's lead person for referrals of people for DoLS applications. No applications had so far been required, but the registered manager was following advice from the lead person.

People were able to follow their individual choices. For example, they were offered their meals at times that suited them and these meal times were flexible. Two people were eating breakfast in the dining room at 10.30, while others had eaten their breakfast earlier. Staff told us that another person "Never got up for breakfast but likes to start their day with lunch". Staff asked each person on a daily basis what their choice of meal was and handed the list to the cook in the morning. People who could not express themselves were offered meals based on what staff knew about their likes and dislikes. The cook was informed of people's particular likes and dislikes by the staff and people's relatives. During lunch, staff were allocated to assist people who needed help with eating and drinking. Staff sat next to people and talked to them whilst helping them eat and drink. Staff prompted people to eat and drink in a friendly and helpful way.

People showed enjoyment of their meals, smiling and saying they liked the food. A choice was offered at every meal time. The menus showed that a balanced and nutritional diet was provided. The cook told us that fresh fruit and vegetables were prepared every day and we saw that these were served to people. The cook knew how to provide for special diets, and a few people who had low weights were being given additional snacks and build-up drinks. Some people had diabetic diets. Staff said that snacks such as sandwiches, biscuits and cakes were offered to people outside of meal times. People were assessed to establish if they were nutritionally vulnerable using a professionally recognised process. People were referred to the GP and dieticians when necessary and were assessed on a regular basis. The advice of health professionals such as speech and language therapists was taken, (for example, for people with swallowing difficulties), and clear records were kept.

A GP visited the service each week, or more frequently if the need arose. The registered manager told us that several people had shown symptoms of chest infections during the previous few days, and the doctor had visited all of these people on the day before our inspection. Some people had mental health difficulties as well as living with dementia. They were supported by visits from other health professionals such as a community psychiatric nurse. A health professional told us that staff were "Very good at picking up physical health problems and contacting the GP; and very quick to respond to suggestions or recommendations".

A relative told us that when her father had been ill, the care staff had changed his position every three to four hours, and at a later date, every two hours, to prevent pressure sores. The district nurse went in to see him every day.

Care plans contained health care assessments, such as people's previous medical history, current illnesses, and prescribed treatments. Visits were requested from other health professionals such as opticians, podiatrist, and dentists, and details of their visits were recorded.

Good

Is the service caring?

Our findings

People said that they were happy living in the home, and liked living there. Relatives spoke highly of the care that their family members received, with comments such as, "The care is amazing", and "The staff are wonderful". Responses to yearly questionnaires for people and their relatives, showed positive responses to questions such as, 'How satisfied are you with the overall care'. All the replies to a recent survey gave the answers as 'satisfied' or 'very satisfied'. A relative said, "Staff always make me welcome"; and another said they could phone at any time to ask about their relative's progress.

Staff were friendly and shared good relationships with people living at the service and their relatives. We observed staff engaging people in conversation, and laughing with them. They re-orientated people to the season and the time of day, and showed patience when people repeated the same questions. Staff reacted quickly when people became upset or angry, and approached people in different ways depending on their needs and their characters. People were given reassurance or were gently distracted to calm them. People were treated with respect, and their privacy and dignity was maintained. For example, staff discreetly helped people to adjust their clothing after they had been to the toilet. Personal care was given behind closed doors. Environmental checks for people's bedrooms included checking that people's curtains closed properly so that their privacy was protected during personal care; and if they could access their call bell and it was working properly. People were provided with a locked facility in their bedrooms for any items they wished to store confidentially.

People were given the explanations they needed. One person who was feeling unwell kept asking what they should do as they felt so unwell. Staff patiently reassured them and reminded them that they had seen the doctor the previous day and were having medicine to make them better. Staff encouraged people to be as independent as possible. For example, one person was provided with a plate guard at lunch time, which helped them to eat their meal independently. People were facilitated to find their own rooms as their bedroom doors had their names and photographs or pictures on them.

Information about people's care was stored confidentially. Relatives who acted on behalf of people were kept informed of any changes in their health or care needs. The registered manager supported people if they required advocacy services. These provide independent support for people when they need help to express their views or to make decisions about their lives. The registered manager told us that none of the people who lived at the home had advocates but they would be supported if they needed to access these services.

During our inspection a relative visited the service after their family member had recently died. They spoke very positively about the care their loved one had received, and expressed their wish that we would include their comments in our report. They said that when their family member was coming to the end of their life, they were able to visit at any time, and staff showed them compassion and thoughtfulness throughout this time. They said, "The manager and staff were fantastic. Our relative had amazing care. You couldn't fault them. Staff sat with him while they were waiting for us to come in. We could stay as long as we wanted, and they always offered us drinks and sandwiches. We are so grateful for all their kindness."

Care plans included people's preferences about their end of life care. These included their wishes to stay in the home or go to a hospital or hospice if it was indicated; if they would like the staff to contact any religious leaders; and if they had any specific wishes.

Requires improvement

Is the service responsive?

Our findings

People and their next of kin or representatives were invited to be involved in their care planning. Care plans included mental capacity assessments which showed the extent to which people could take part in making their own decisions about their care. However, some care plans did not contain much information about people's past histories or life styles, their interests or hobbies. The registered manager told us that this part of the care planning was usually carried out by an activities co-ordinator, but the service was currently without an activities co-ordinator, and she was recruiting for this post.

Care staff had general knowledge about people's backgrounds and characters, and how to distract them if they were upset; and they spent time chatting to people. However, there was a lack of on-going activities and stimulation for people living with dementia. This did not ensure the welfare of people living in the service. The front lounge included a large number of games and books, but these were not taken through to the main lounge where most people chose to congregate. There were no sensory items, or items which could remind people of previous lifestyles, and help them to reminisce. The registered manager said that she had recognised the need for more stimulation for people and had purchased some posters of war time events and classic films to put on display. She had also increased visits from entertainers (such as singers, and 'Music for Health') while a new activities co-ordinator was being recruited.

During the inspection people talked together, watched television, listened to music, or walked about. A health professional told us there was a "Lack of stimulation" for people throughout the day, but said that care staff "Went out of their way to try and take people out". The service had an area at the front of the building where people could sit in good weather and watch people and traffic going past; and there was a small garden at the rear. The rear garden could only be accessed by stepping over a step on to a ramp, and then by two further steps down to a small lawn. It was therefore only available to people who had full mobility. The garden did not have any other items to make it an interesting and inviting area in which to sit.

The lack of activities was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans contained suitably detailed information about their physical health and care needs. They included different aspects of daily living such as people's personal care, mobility, nutrition, continence, health needs and sleeping. They included directions to help staff, such as 'Is able to wash own hands and face'; 'Ensure is wearing well-fitting shoes to prevent falls'; and 'Can make own food choices'. Care plans were reviewed monthly, and were updated to show changes in people's care needs. Care staff completed daily reports at the end of each shift, and carried out a minimum of hourly checks at night. They recorded any activities carried out, such as people having visitors, having their hair done, or watching television; and recorded if there were any health concerns or behavioural changes. Additional charts were used to document details of people's personal care, showing if they had had a bath or a shower, hair wash, shave, and if their bed linen had been changed. Separate charts were used to record positional changes for people who were unwell; and to record people's fluid intake and output where this was important for their health needs. These charts were accurately completed.

Staff encouraged people to voice their feelings. Relatives told us that the care staff and the registered manager were approachable and listened to them. People were informed about the complaint procedures when they were admitted to the service, and these were included in the contract for the terms and conditions of residency. A copy of the complaints procedure was kept on display in the front entrance hall. On the day of our inspection this had been removed by one of the people living in the service. The registered manager told us that a new display cabinet had been ordered, which would enable staff to display notices without people removing them.

The complaints procedure stated that all complaints would be acknowledged within three days, and the registered manager would carry out a full investigation. Details were provided for the regional manager and for other regulatory bodies, including CQC. Complaints were responded to within 28 days. The manager carried out a monthly audit for complaints, and they were reviewed by the head office. There had been one formal complaint within the last year, which showed evidence of a relevant investigation and response. The registered manager told us that small everyday concerns were dealt with promptly, and were used as a learning point to bring about on-going improvements.

Requires improvement

Is the service responsive?

A relative told us that they could phone “Any time” if they had any questions or concerns, and were confident that their concerns would be listened to and would be appropriately addressed.

Requires improvement

Is the service well-led?

Our findings

People and their visitors said that the registered manager and staff were approachable, and they could talk to them at any time. The registered manager had an open door policy and made herself available at weekends as well as on week days. A relative said "The home seems to run smoothly, and the staff work well together".

Auditing processes were carried out to check the progress of the home. Some of these were weekly and some monthly. They included audits for how care was given, for dining, housekeeping, laundry, equipment, staffing, comments and complaints, and record-keeping. These were carried out reliably, and information gathered was used to bring about on-going improvements in the service. However, the audits did not all provide a full picture of different aspects of the service. For example, infection control audits had failed to identify that the service did not have a clear procedure for cleaning commodes; and had failed to show that laundry services did not include required facilities such as a separate hand washing basin. Health and safety audits had failed to show that there was a lack of equipment for moving people with restricted mobility from upstairs rooms in the event of an emergency.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were stored so as to protect people's confidentiality. Daily records and charts were correctly completed and provided on-going information. Some care plans had not been fully completed in regards to recording people's life histories and social preferences. Policies and procedures were provided for different aspects of running the service. These had been provided centrally by the company, but did not always match up to local practices and procedures. For example, they included a restraint policy and procedure, but restraint was not carried out in the service. We saw 12 infection control policies and procedures, but these did not include a policy and procedure for cleaning commodes. The registered manager agreed that the policies needed to show clearly how practices were carried out in this service, and said that she would review them during the coming weeks to ensure they were an accurate reflection of how things should be done.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Audits were checked by a quality assurance compliance officer for the service. Each audit produced a score, and some of the audits showed very positive results. For example, the service had scored 100% throughout the previous year for keeping staff training programmes, supervisions and appraisals up to date. A monthly action plan was drawn up in response to audit findings. For example, the registered manager had arranged additional entertainment visits from external groups in response to the lack of group activities whilst recruiting for an activities co-ordinator. The registered manager checked the previous month's action plan when completing audits, to see that items on the action plan had been achieved or commenced.

Staff said that the registered manager led the staff team in overseeing people's care, and in ensuring that staff carried out their responsibilities in accordance with their training. The registered manager arrived at the service early each day so that she could talk with night staff, and assess their development. This provided them with the opportunity to raise any questions about people's care, or any concerns. Staff said that they felt involved in the running of the home as they had daily handovers between shifts, and staff meetings, when they could discuss different issues raised. The registered manager ensured that staffing numbers on shifts were maintained, through requesting staff to work additional hours to cover annual leave or sickness; and through the use of agency staff if necessary. The service used the same agency and requested the same agency staff where possible, so as to provide continuity of care for people.

Health professionals said that the registered manager and staff contacted them appropriately to request reviews for individual people, or to ask for advice. They said that the staff followed their advice and were "Very quick to respond to suggestions and recommendations". Health professionals and people's relatives said that the staff maintained good communication with them, and informed them about changes in people's health or welfare.

The registered manager kept her own training up to date. She had completed the Registered Manager's Award and a National Vocational Qualification (NVQ) level 4 in management, and was studying for level 5. (NVQs are work based awards that are achieved through assessment and

Requires improvement

Is the service well-led?

training). During the past year she had carried out refresher courses in mental health, dementia care, end of life, medicines, health and safety, and moving and handling. Her dementia training was bringing improvements to people's dementia care as a result. The registered manager attended meetings with other registered managers from the same company, and this enabled them to share examples of good practice and discuss how to resolve issues.

The registered manager and staff maintained links with the local community. This was especially important for people living in the service who had previously lived in this area. As well as links with local schools and church groups, the registered manager ensured that the service was involved in the local regatta which was a yearly event in the town. This included having their own stall. Other local events included May Day, when people living in the service were enabled to visit the local castle and take part.

The registered manager arranged three-monthly questionnaires for people living in the service. This helped them to share their views on a regular basis. The questionnaires were provided in large print to assist people, and were written with simple questions so that they were easy to understand. Some people needed help from their relatives or staff to complete questionnaires, and this was indicated at the beginning. Questionnaires covered a range of subjects, such as the home's décor and furnishings, the variety of food and drink, general tidiness and cleanliness, and the way in which any problems or issues were dealt with.

Relatives and visiting health professionals were invited to complete annual questionnaires, and to add their comments. Results from the last year had been positive, and comments included, "Staff make me welcome"; "I am given access to all required information"; "The overall impression of the home is good"; and, "The home environment has been improved by the extension and renovation. I receive good communication from the staff". The results from questionnaires were used to make on-going improvements in the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider did not ensure that service users, staff and visitors were protected against identifiable risks of acquiring infections, as appropriate standards of cleanliness and hygiene were not in place. The provider was not following the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. (Regulation 12)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider did not have suitable procedures in place for dealing with emergencies which might reasonably be expected to arise from time to time; in that there were insufficient arrangements and equipment for people with restricted mobility in first floor rooms in the event of an emergency. (Regulation 9 (2))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure that people living with dementia had sufficient activities and stimulation to ensure their welfare. (Regulation 9 (1) (b) (i) (ii))

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider had not protected people against the risks of unsafe care or treatment, by means of effective systems to monitor the quality of services provided. And had not identified, assessed and managed risks relating to the health, welfare and safety of people using the service and staff. (Regulation 10 (1) (a, b), (2) (a))
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider had not ensured that records for the management of the regulated activity were kept up to date and included all aspects of the running of the service. (Regulation 20 (1) (ii))