Care Quality Commission

Tamaris Healthcare (England) Limited

# Rydal Care Home

## Inspection report

Rydal Road
Darlington
County Durham
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## Ratings

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

# Summary of findings

## Overall summary

The inspection took place on 24 February 2016. The inspection was unannounced.

Rydal is a residential care home with nursing based in the Lascelles area of Darlington, County Durham. The home provides personal care and nursing care to older people and people with dementia type conditions. It is situated close to the town centre, close to local amenities and transport links. The service was registered for 60 people and at the time of our inspection there were 41 people using the service.

The home had a registered manager. 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.

We spoke with a range of different team members; care, nursing, kitchen, maintenance, laundry, activities co-ordinator and student nurses who told us they felt well supported and that the registered manager was supportive and approachable. Throughout the day we saw that people who used the service and staff were comfortable, relaxed and had a positive rapport with the registered manager and with each other. The atmosphere was welcoming, and relaxed. We saw that staff interacted with each other and the people who used the service in a friendly, supportive, positive manner.

From looking at people's detailed care plans we saw they were in two parts. One held personal information and detailed accounts of care needs and a record of daily activity. The second file in addition to the care plan files was a person centred file that was stored in people's bedrooms and these included a 'one page profile' that made good use of pictures, personal history and described individuals likes, dislikes, care and support needs. Both were regularly reviewed and updated by the care staff and the registered manager.

Individual care plans contained risk assessments. These identified risks and described the measures and interventions to be taken to ensure people were protected from the risk of harm. The care records we viewed also showed us that people's health was monitored and referrals were made to other health care professionals where necessary, for example: their GP, optician  or chiropodist.

Our observations during the inspection showed us that people who used the service were supported by sufficient numbers of staff to meet their individual needs and wishes.

When we looked at the staff training records they showed us staff were supported and able to maintain and develop their skills through training and development opportunities were accessible at this service.
The staff we spoke with confirmed they attended a range of training opportunities but not in dementia awareness. These types of specific courses help to raise awareness and meet the needs of the people who use the service and those living with dementia.
We saw that the physical environment throughout the home was not dementia friendly and did not always

reflect best practice in dementia care or meet the standards set out in national guidelines.
They told us they had regular supervisions and appraisals with the registered manager, where they had the opportunity to discuss their care practice and identify further mandatory and vocational training needs. We also viewed records that showed us there were robust recruitment processes in place.

We observed how the service administered medicines and how they did this safely. We looked at how records were kept and spoke with the nursing staff about how this was carried out and how senior staff was trained to administer medicine and we found that the medicine administering process was safe.

People were encouraged to participate in activities that were organised, including, outings and regular entertainers. We saw staff spending their time positively engaging with people as a group and on a one to one basis in activities. We saw evidence that people were not only being supported to go out and be active in their local community, but were also valued members of the local community and helped the local school to manage their vegetable plot.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. We observed people being offered a varied selection of drinks and fresh homemade snacks. The daily menu that we saw offered choices and it was not an issue if people wanted something different.

We saw a complaints and compliments procedure was in place. This provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. The compliments that we looked at were complimentary to the care staff and the service as whole. People also had access to advocacy when we inspected and there were services promoted if needed.

We found an effective quality assurance survey took place regularly and we looked at the results. The service had been regularly reviewed through a range of internal and external audits. We saw that action had been taken to improve the service or put right any issues found. We found people who used the service and their representatives were regularly asked for their views at meetings.

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

We always ask the following five questions of services.

### Is the service safe?

**Good**

There was sufficient staff on duty to safely cover the lay out of the building and the needs of the people using the service.

The service had an efficient system to manage accidents and incidents and learn from them so they were less likely to happen again.

Staff knew what to do when safeguarding concerns were raised and they followed effective policies and procedures.

Medicines were managed, reviewed and stored safely.

### Is the service effective?

**Requires Improvement**

This service was not always effective.

The environment of the service was not adapted to be dementia friendly.

The service had developed a supervision structure to regularly supervise staff.

Staff were not appropriately trained with the skills and knowledge to meet people's assessed needs, preferences and choices relating to dementia awareness.

The service understood the requirements of the Mental Capacity Act 2005, its Codes of Practice and Deprivation of Liberty Safeguards, and put them into practice to protect people.

### Is the service caring?

**Good**

This service was caring.

People and their families were valued and treated with kindness and compassion and their dignity was respected.

Care staff were knowledgeable of, and people had access to advocacy services to represent them.

People were understood and had their individual needs met, including needs around social isolation, age and disability.

## Is the service responsive?

**Good**

This service was responsive.

People received care and support that reflected their preferences, interests, aspirations and diverse needs.

People and those that mattered to them were actively involved and able to make their views known about their care, treatment and support.

People had a range of activities and outings to access, that they valued.

A robust complaints and compliments procedure was in place and used appropriately.

## Is the service well-led?

**Good**

This service was well led.

The manager had an approach that supportive and promoted an open culture.

Staff were supported to question practice and those who raised concerns and whistle-blowers were protected.

There were effective quality assurance systems in place to continually review the service including safeguarding concerns, accidents and incidents. Investigations into whistleblowing, safeguarding, complaints/concerns and accidents/incidents were thorough.

There were good community links and partnership approaches to tackling social isolation and inclusion.

Care Quality Commission

# Rydal Care Home

## Detailed findings

## Background to this inspection

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

This inspection took place on 24 February 2016 and was unannounced. This meant that the service was not expecting us. The inspection team consisted of one Adult Social Care inspector and a specialist advisor with an older people and nursing background. At the inspection we spoke with four people who used the service, two relatives, the registered manager, the locality manager, the activities co-ordinator, two nursing staff, four care staff, two kitchen staff, two student nurses, maintenance and laundry staff.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service; including; the local authority commissioners and no concerns were raised by these professionals.

Prior to the inspection we contacted the local Healthwatch and no concerns had been raised with them about the service. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work.

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 used this information to inform our inspection.

During our inspection we observed how the staff interacted with people who used the service and with each other. We spent time watching what was going on in the service to see whether people had positive experiences. This included looking at the support that was given by the staff, by observing practices and interactions between staff and people who used the service.

We also reviewed records including; staff recruitment files, medicines records, safety certificates, care plans and records relating to the management of the service such as audits, surveys, minutes of meetings, and policies.

Good

# Is the service safe?

## Our findings

The people who used the service that we spoke with told us they felt safe living at Rydal care home. One person who used the service told us, "Yes I am safe here; the nurse comes round to help me with my tablets." Another told us, "I'm safe because everything is going smoothly and there is no trouble."

The service had policies and procedures for safeguarding adults and we saw these documents were available and accessible to members of staff. This helped ensure staff had the necessary knowledge and information to make sure that people were protected from abuse. Together with the comments we received during the inspection this showed us that people felt safe and were happy.

The staff we spoke with were aware of who to contact to make safeguarding referrals to or to obtain advice from. The registered manager said abuse and safeguarding was discussed with staff on a regular basis during supervision. Staff we spoke with confirmed this happened and we saw that safeguarding was a regular team meeting agenda item. Staff told us that they had received safeguarding training within the last three years. They said they felt confident in whistleblowing (telling someone) if they had any worries. One staff member told us, "Yes I know what to do and I know how to raise concerns and who to, there are blue notices up with the contacts on for people to see too." This showed us that staff were informed and confident to react to safeguarding issues.

The service had a Health and Safety policy that was reviewed and up to date. This gave an overview of the service's approach to health and safety and the procedures they had in place to address health and safety related issues. We also saw that a personal emergency evacuation plan (PEEP) was in place for people who used the service. This was also kept in the services emergency 'grab bag' that held everything needed in an emergency. The PEEPs provided staff with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency.

We saw records of maintenance and monthly health and safety checks for the equipment used in the home to support this. We also saw records of other routine maintenance checks carried out within the home. These included regular portable appliance testing (PAT) checks of electrical equipment, water temperatures, room temperatures and cold water storage. This showed that the provider had in place appropriate maintenance systems to protect staff and the people who used the service against the risks of unsafe or unsuitable premises or equipment.

Regular fire alarm testing was carried out in the home and we saw the records that recorded this along with; fire door checks, escape routes, fire extinguisher checks and emergency lighting testing.

We looked at the arrangements that were in place to manage risk, so that people were protected and their freedom supported and respected. We saw that risk assessments were in place in relation to the people's needs such as; nutrition falls and skin care. This meant staff had clear guidelines to follow to mitigate risks.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the

risk of re-occurrence.  The locality manager showed us this system that was online and explained the levels of scrutiny that all incidents, accidents and safeguarding concerns were subjected to within the home. They showed us how actions had been taken to ensure people were immediately safe.

The staff files we looked at showed us that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults.  This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults.

On the day of our inspection there were 41 people using the service. We found the layout of the home was spread over two floors. On each floor there were bedrooms which each were personalised. The service also had several small shared lounge areas for people to use. On the ground floor there was a dining area small lounges for everyone to access and all of them were used regularly for events. We saw that that people could choose which lounge to sit in and people had their preferences.

We spoke with the registered manager about staffing levels, they told us they were using a dependency model and explained how this was calculated on a monthly basis but that they brought extra staff in when needed. They explained how the dependency tool worked out how many staff were required to care for people based on the numbers of people using the service and their needs We found there were enough staff on duty to meet people's needs.

During the inspection we observed the nursing staff administer the medicine. We discussed all aspects of medicines with the nursing staff and senior staff that had a thorough knowledge of policies and procedures and a good understanding of medicines in general. We saw that the controlled drugs cabinet was locked and securely fastened to the wall. We saw the medicine fridge daily temperature record. All temperatures recorded were within the 2-6 degrees guidelines. We saw the medicine records which identified the medicine type, dose, route e.g. oral and frequency and saw they were reviewed monthly and were up to date. We audited the controlled drugs prescribed for two people; we found both records to be accurate. Controlled Drugs were checked at the handover of each shift.

We saw there was evidence of sample signatures of staff administering medicines. There was also a copy of the home's policy on administration, and 'as and when required' medicine protocols. These were readily available within the MARs folder so staff could refer to them when required. Each person receiving medicines had a photograph identification sheet and preferred method of administration documented. Any refusal of medicines was recorded on the MAR record sheet and all medicines for return to the pharmacy were disposed of safely.

We saw that one person was receiving medicines covertly, this means when someone doesn't have capacity and refuse their medicines then it may be given in a different format to enable it to be taken. The decision to give medicines this way had been taken correctly. The individual was involved in a 'best interest decision' and this was done by involving an advocate for the person, their GP and the nursing staff to discuss the risks and benefits before deciding.

We found there were effective systems in place to reduce the risk and spread of infection.  We found all areas including the laundry, kitchen, bathrooms, lounges and bedrooms were clean, pleasant and odour-free. Staff made use of protective clothing and equipment and were trained in infection control.

Requires Improvement

# Is the service effective?

## Our findings

During the inspection we spent time in all areas of the home used by service users. The home provides a service to people with dementia type illnesses on both the ground and first floor of the home, people with more advanced dementia type illnesses being located on the first floor. Other than the pictures of toilets and shower rooms placed on doors and some memorabilia pictures there was no further evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom/bedroom doors. Corridors were all similar in colour, and bedroom doors did not have a picture or memory box people could associate with to help them find their personal space.

We saw that the physical environment throughout the home did not always reflect best practice in dementia care. The NICE Guidelines 'Dementia: Supporting people with dementia and their carers in health and social care 2006' states; 'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'.

Some redecorating had commenced but not in the hallways or stairs and of the carpets and soft furnishings around the service were also tired and in need of replacing. The registered manager told us that a redecorating programme was still underway and they were aware of the carpets and soft furnishings that needed replacing. This meant that the environment was not suitable for people living with dementia.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the staff training files and the training matrix that showed us the range of training opportunities taken up by the staff team. The courses included; end of life care, medicine, food safety and vocational training for personal development. We could also see that staff either had or were working towards their NVQ (National Vocational Qualification) Levels two and three in health and social care. One member of staff told us, "The training is there to help us." the registered manager told us how the training was transferring between systems and how the change was making training more appropriate for monitoring.

From looking at the training matrix and five staff training records we found that staff were not trained in dementia awareness both the registered manager and the locality manager assured us that this would be addressed and that a new programme of dementia training was beginning. The locality manager told us "The new dementia training starts this month the managers attend first then the care staff." At the time of our inspection the service was providing care to people living with various types of dementia.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For any new employee, their induction period was spent shadowing more experienced members of staff to

get to know the people who used the service before working alone. New employees also completed the Care Certificate' induction training to gain the relevant skills and knowledge to perform their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The certificate has been introduced to give staff new to caring an opportunity to learn Staff had the opportunity to develop professionally by completing the range of training on offer. Training needs were monitored through staff supervisions and appraisals and we saw this in the staff supervision files.

The service had developed a 'champions scheme' that developed staff to lead on a particular area with their peers these included; infection control, first aid, online training, moving and handling and fire safety. We saw that this was clearly on display and discussed in team meetings.

We saw staff meetings took place regularly. During these meetings staff discussed the support they provided to people and guidance was provided by the registered manager in regard to work practices and opportunity was given to discuss any difficulties or concerns staff had. The meetings covered the following on a regular basis; safeguarding, standards and training.

Individual staff supervisions were planned in advance. Appraisals were also carried out annually to develop and motivate staff and review their practice and behaviours. From looking in the supervision files we could see the format of the supervisions gave staff the opportunity to raise concerns and discuss personal development.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. Throughout the inspection we observed people being offered a selection of drinks and fresh homemade snacks and support to have them if needed. Drinks were also out in people's rooms and jugs of juice were out in communal areas for people to access. The menu that we looked at was balanced and offered two choices at every meal and was compiled with the people who used the service to reflect their favourite meals. We could see that if a person didn't want what was on the menu or even changed their mind that this was not a problem and other options could be arranged. The kitchen staff told us, "The mixed grill was taken off the menu because people didn't like it. We always make separate meals for people who don't want what is on the menu."

The inspection team observed the people who used the service having their lunch in the dining room. We could see that there were enough staff available to support people and staff were encouraging and supporting people who needed assistance. The atmosphere in the dining area was relaxed and the people who used the service were enjoying their lunch, chatting to staff and giving positive feedback. We observed that some people chose to have their meal in their room and this was supported by the staff. One person who used the service told us, "There is always plenty to eat and plenty of drinks. We are all well looked after here."

From looking at people's care plans we could see that the MUST (Malnutrition Universal Screening Tool) focus on under nutrition was in place, and up to date. Food and fluid intake records were used when they were needed. We saw that special diets were managed and the kitchen staff had up to date information of people's needs on display in the kitchen. The kitchen staff told us, "I've been on training in MUST and First aid and I'm going on another to learn about thickeners." When asked the kitchen staff if they took on board peoples preferences and they told us "I go and talk to people to find out what they like."

We saw that people's weight was managed and was recorded regularly. Where supplements or other changes to diet were required this was also recorded. When we asked the kitchen staff how they prepared different meals for individuals they said; "We make things separate for those who need supplements and we add them to the mouse and yoghurts." The kitchen staff also showed us the planned menu and the choices

for that day and how it was recorded. The staff also showed us their white board that had people's allergies and needs at a glance. This showed us that the kitchen staff communicated well with the rest of the team and had knowledge of individual's likes, dislikes and nutritional needs.

We saw in two peoples care plans that on admission to the service they had a weight loss and since admission they both had made significant progress and gained weight and had involvement from dieticians and the speech and language team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There were a number of people who used the service who had DoLs in place. The remaining applications had gone to the local authority for processing at the time of our inspection. We also saw in the staff training records that staff had received training on DoLs and the MCA. When we spoke to the registered manager they explained the process they followed that complied with the local authority MCA and DoLs guidance.

Mental Capacity Assessment records we looked at confirmed that where necessary, assessments had been undertaken of people's capacity to make particular decisions. We also saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. We saw an example of this regarding medicine administration. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised .Consent to care and treatment records were signed by people where they were able and if they were unable to sign a relative or representative had signed for them.

Good

# Is the service caring?

## Our findings

When we spoke with the people who used the service they told us that the staff were caring, supportive and helped them maintain their independence.  One person who used the service told us; "They're all very caring." And "I'm happy with the staff they're all very obliging." Another told us, "[name] really looks after us, she's very good to us, and she's very nice."

Without exception we saw staff interacting with people in a positive, caring and professional way. We spent time observing support taking place in the service. We saw that people were respected by staff and treated with kindness. We observed staff treating people respectfully.  We saw staff communicating well with people and enjoying activities together. We observed staff using humour to engage people and encouragement to calm people when distressed. When we spoke with relatives we asked them how the staff treated them and their family members. And one relative told us "We are always made to feel welcome when we come here." This showed us that people were supported by very kind, caring and dedicated staff.

Staff were motivated and knew the people they were supporting very well, and had good relationships with them and their families. They were able to tell us about people's life histories, their interests and their preferences. We saw all of these details were recorded in people's person centred plan in their bedrooms. The staff we spoke with explained how they maintained the privacy and dignity of the people that they cared for at all times and told us that this was an important part of their role. One member of staff told us; "When I'm supporting someone with showering I make sure people are covered and always ask them what they want first."

Throughout the inspection there was a relaxed atmosphere at the service.  We found the staff were affectionate and people were treated with dignity and respect and privacy was important to everyone. We spent time observing people in the lounges, dining area and around the home and we saw staff knock on peoples door first and being discreet.

Where possible, we saw that people were asked to give their consent to their care, before any treatment and support was provided by staff. Staff considered people's capacity to make decisions and they knew what they needed to do to make sure decisions were taken in people's best interests and where necessary involved the right professionals. We saw that there was information on display for visitors and people who used the service to see that held the relevant information for advocacy. We also could see that some people already had access to an advocate and one person had one to help them make decisions about medicines. This meant people who used the service had access to others who could act on their behalf and in their best interests.

We saw records that showed us a wide range of community professionals were involved in the care and treatment of the people who used the service, such as, dieticians, speech and language therapy and opticians. Evidence was also available to show people were supported to attend medical appointments and we observed this during our inspection.

During our inspection, we saw in people's care plans that people were given support when making decisions about their preferences for end of life care. In people's care records we saw they had made advanced decisions about their care regarding their preference for before, during and following their death. This meant people's physical and emotional needs were being met, their comfort and well-being attended to and their wishes respected. At the time of our inspection there was no one in receipt of end of life care.

Good

# Is the service responsive?

## Our findings

During the inspection we could see there was a weekly timetable of activities. There were some organised activities going on in the afternoon but not in the morning as the activities co-ordinator had to leave to support a person to attend an appointment.  We observed some one to one activities taking place and these were; hand massage and nail care and others were knitting. Everyone else was either in their rooms or watching TV.

We were able to talk with people about the activities and one of the people using the service told us how they enjoyed the planned activities and they told us; "We play bingo and we run raffles to raise funds. We go to the sing song or when the singers come in, I enjoyed that. We have had animals come in, tiny ones, I didn't like them but that's my choice." The activities Co-ordinator told us "We discuss activities at the residents meetings and they tell me what they want to do, it's their choice at the end of the day and I let them decide what we do." Although we observed limited activities at the time of our inspection people told us that the activities were valued. The registered manager also assured us that more was planned to improve them.

We saw that people were involved in planning the activities and regular resident's meetings were held to discuss and organise activities. We could see that there was a range of activities planned for people to choose from including:  bingo, arts and crafts, crafty critters and upcoming events included a mother's day dinner and a garden party. The people who used the service and the staff told us about the relationship they had with the local community especially the relationship they had with the local school. The Activities co-ordinator told us, "We work closely with the school next door, we have a vegetable plot it's a joint project. We help to take care of it and we can enjoy what is grown. The school also come into the home we held a poetry competition called 'Young at Heart' we will go into the school to judge the poems and present the winners with a prize." This meant people were protected from social isolation and were encouraged to remain involved and part of their wider community.

The main care plans that we looked at were not person centred or written in an easy read format they had numerous sections relating to different aspects of care and held daily activity logs and risk assessments and these were reviewed regularly. The service held separate files in peoples bedrooms called 'my journal' and these contained in depth details of their likes and dislikes. These additional care plans gave an insight into the individual's personality, preferences and choices. The care plan held a 'one of a kind - one page profile' that listed all that you would need to know to care for that person in a person centred way.  Peoples histories were also recorded in the 'my journal' these were easy to follow and some included photographs.

We saw people were involved in developing their care plans. We also saw others who mattered to them, where necessary, were involved in developing these plans. The registered manager explained that these additional files worked well being kept in people's room so that they and their relatives can access them. One member of staff told us "We always give them their choices for example giving people the opportunity to go out and we put things into the care plan so that others know. We actually have some more person centred planning training planned."

We saw that peoples preferences were recorded in the medicines record in a person centred way for example one stated, '[name] likes a glass of water, tablets one at a time from a spoon.' Another stated 'medicines in a pot then tipped into [name] hand, and then a large glass of water.' This showed us that their choices were respected.

When we asked the staff if they knew how to manage complaints they told us; "Yes I would take it to the manager, no problem." We looked at the complaints file and we saw that complaints had been responded to and were fully investigated. The outcomes of each complaint were recorded and complainants had received a copy of the outcomes. This showed us that the complaints procedure was well embedded in the service and staff and visitors were confident to use it when needed.

A handover procedure was in place and we saw the completed record that staff used at the end of their shift. Staff said that communication between staff was good within the service. The handover covers each person and included their daily patterns any wellbeing issues, visits or appointments and was clearly recorded and complete. This showed us that communication between shifts was in place.

Good

# Is the service well-led?

## Our findings

At the time of our inspection visit, the home had a registered manager who had been in post since October 2015. A registered manager is a person who has registered with CQC to manage the service. One member of staff told us; "The manager is spot on, he is always there for us." another told us "He is still finding his feet."

The registered manager was qualified, competent and experienced to manage the service effectively. We saw there were clear lines of accountability within the service and with external management arrangements with the provider. We saw up to date evidence of inspection records from the company's head office covering; people who used the service, their views/concerns, staffing, suggestions for improvement, meals, complaints, accident and incident analysis, maintenance records, fire safety, admissions, care plans, and social activities.

The staff members we met with said they were kept informed about matters that affected the service by them. They told us that staff meetings took place on a regular basis and that they were encouraged by the registered manager to share their views. We saw records to confirm this. We could see that the registered manager held regular staff meetings. One member of staff told us "We have staff meetings and we can bring up issues they are really good."

When we spoke with the registered manager, he told us about new initiatives that he was implementing regarding the staff and one was to change the supervisions to a 'cascade' process and this involved training senior staff to take on board supervision of care staff. The registered manager told us, "The senior staff will be given a group to be responsible for to supervise."

We saw that the registered manager had an open door policy to enable people and those that mattered to them to discuss any issues they might have. The registered manager showed how they adhered to company policy, risk assessments and general issues such as trips and falls, incidents, moving and handling and fire risk. We saw analysis of incidents that had resulted in, or had the potential to result in harm were in place. This was used to avoid any further incidents happening. This meant that the service identified, assessed and monitored risks relating to people's health, welfare, and safety.

We saw there were arrangements in place to enable people who used the service, their representatives, staff and other stakeholders to affect the way the service was delivered. For example, the service had an effective quality assurance and quality monitoring system in place. These were based on seeking the views of people who used the service, their relatives, friends and health and social care staff who were involved with the home. These were in place to measure the success in meeting the aims, objectives and the statement of purpose of the service.

We discussed partnership working to tackle social isolation with the registered manager and they explained to us how they maintained links with the local community especially the school next door and the local churches and local councillors.

The complaints records that we looked at provided a clear procedure for staff to follow should a concern be raised. We saw there had been one recent complaint made and there was evidence that the registered manager had investigated, recorded the complaint and responded appropriately.

We saw the system for self-monitoring included regular internal audits such as accidents, incidents, building, fire safety, control of substances hazardous to health (COSHH), fixtures and fittings, equipment and near misses.

The service had a clear vision and set of values that included honesty, involvement, compassion, dignity, independence, respect, equality and safety. These were understood and consistently put into practice. The service had a positive culture that was person-centred, open, inclusive and empowering. The registered manager told us, "The move to put people's person centred files in their rooms as this was their preference." We saw that values were reflected in the staff supervisions and at team meetings.

We saw policies, procedures and practice were regularly reviewed in light of changing legislation and of good practice and advice. The service worked in partnership with key organisations to support care provision, service development and joined- up care. Legal obligations, including conditions of registration from CQC, and those placed on them by other external organisations were understood and met such as, Department of Health, Local Authorities and other social and health care professionals. This showed us how the service sustained improvements over time.

We discussed the services plans to introduce a new corporate dementia strategy that would introduce new ways if working and include training for all managers and staff. The registered manager and regional manager told us that these plans were imminent.

We looked at the processes in place for responding to incidents, and accidents. These were all assessed by the registered manager using an on line system and following this a weekly report was sent to the regional manager for analysis along with the registered manager's weekly report on the progress of the home. We found the provider reported safeguarding incidents and notified CQC of these appropriately.

We saw all records were kept secure, up to date and in good order, and maintained and used in accordance with the Data Protection Act.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>We found that the environment of the service was not suitable for people living with dementia. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not appropriately trained in dementia awareness to meet the needs of the people who use the service who are living with dementia. |