Beechtree House Limited

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Inspection report

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Ratings

Overall rating for this service	**Good**
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**

Overall summary

The inspection was unannounced and carried out by two inspectors over two days on 19 January 2015 and 20 January 2015.

Beechtree House Limited provides care and accommodation for up to 24 older people, some of whom are living with dementia. The property is a period building with more modern adaptations. The majority of bedrooms are for single occupancy, with two that can be shared. Most bedrooms have en-suite facilities.

Accommodation is over three floors accessed by a passenger lift. There is an enclosed patio area and small car park. Beechtree House is close to Maidstone town centre and local and mainline rail stations.

People had varied communication needs and abilities. Some people were able to express themselves verbally; others used body language to communicate their needs. Some of the people's behaviour presented challenges and was responded to with one to one support from staff.

The provider had notified us that the registered manager had left their post in July 2014 and that the interim management of the service was carried out from August

Summary of findings

2014 by an acting manager. The registered manager was in the process of de-registering with the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert with the provider and local authority if they had any concerns. Staff had completed training in many areas that were essential for their role including dementia care and diabetes. Other training in essential skills had not been arranged for all the staff therefore people could not be assured their care was delivered by skilled and knowledgeable staff.

Risk assessments were centred on the needs of the individual and included assessed risks to people when they were outside the home using local facilities. Each risk assessment included a risk management plan for staff to follow to make sure people were protected from harm.

There were sufficient staff on duty to meet people's needs. Staff had sufficient time to support people in a way that respected individual needs. Staffing levels were calculated according to people's changing needs and dependency levels.

There were robust staff recruitment procedures in place. These included the checking of references and carrying out criminal records checks for prospective employees before they started work. All staff were subject to a probation period and to disciplinary procedures if they did not meet the required standards of practice. All members of staff received one to one supervision sessions every three months and were scheduled for an annual appraisal. Staff told us, "We get good support". This ensured people received care from staff who were appropriately supported in their role.

People's medicines were stored and administered correctly. Staff were trained in the safe administration of medicines and kept medicines administration records that were accurate. The acting manager observed staff practice to check good standards were maintained.

Staff communicated effectively with people, responded to their needs promptly and treated them with kindness and respect. Staff communicated with each person in a way that met their needs and helped them to understand their care and the choices they could make. There was an effective system of communication between staff to make sure they were all aware when people's care needs or health changed.

People's needs were met by adaptations to the service. The building was adapted to provide spacious bedrooms, bathrooms and communal area. The fabric of the building showed signs of wear and tear. The owner discussed with us the improvements that had been carried out and told us about further improvements such as repairs, carpet replacement and re-decoration that were scheduled.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We found the service to be meeting the requirements of the DoLS. Assessments of people's mental capacity were carried out when necessary and meetings were held appropriately to discuss decisions in people's best interest. Staff sought and obtained people's consent before they provided their support.

People were very complimentary about the food provided. The food was home-made, well presented, hot and in sufficient amounts. People were consulted and participated in the planning of menus. People's weight was monitored and people's specific dietary needs were respected. Staff assisted people to eat when necessary at a pace that suited them.

Prompt referrals were made to relevant health services when people's health needs changed. People were referred to health care professionals such as a GP, dietician, psychiatrist, specialist nurses and an occupational therapist when necessary. A chiropodist, an optician and a dentist also visited the service to see people.

People told us they were satisfied with the way staff cared for them. Two people told us, "The staff are very kind and friendly" and, "Everyone is part of a good bunch here". People's diverse needs were accommodated and they were involved in their day to day care. A member of staff said, "We encourage them to speak up and we listen to what they have to say".

Summary of findings

Information about the service was provided to people and visitors and included information about how to complain. Staff were aware of the importance of maintaining confidentiality.

People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity. The staff promoted people's independence and encouraged people to do as much as possible for themselves when it was safe for them to do so.

Staff responded positively and warmly to people. People were involved in their day-to-day care. People's requests for help were responded to without unnecessary delay by staff.

The acting manager ensured that care plans were written taking into account people's life history, preferences and what was important to them. People's individual assessments and care plans were reviewed monthly and updated when people's needs had changed. The staff were made aware of initial assessments of people's needs to ensure they were knowledgeable about people's individual requirements as soon as they came into the service.

There was no activities co-ordinator in post. This vacancy was advertised and the acting manager was interviewing candidates at the time of our inspection. However, in the meantime staff were entertaining people in the afternoons engaging them in indoors activities.

The acting manager sought people's feedback during residents meetings and sent annual questionnaires to people's relatives or representatives to gather their impressions of the service. The acting manager had written an improvement plan that was informed by these surveys. They had implemented changes in the service and carried out audits to further monitor the quality of the service and identify how it could improve. Regular staff meetings were held to discuss the running of the service.

We have made a recommendation about staff training.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about recognising the signs of abuse. Staff knew about and used policies and guidance to minimise the risks associated with people's care.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to safely meet people's needs.

Robust recruitment procedures were followed in practice. Medicines were administered safely. People lived in a clean and safe environment.

Good

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

Not all staff had completed essential training that ensured they were fully knowledgeable in the event of emergencies at the service or infection control.

The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to be able to eat and drink sufficient amounts to meet their needs. People were provided with a choice of suitable and nutritious food and drink.

People were referred to healthcare professionals promptly when required.

Requires improvement

Is the service caring?
The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

Information was provided to people about the service and how to complain. People were involved in the planning of their day to day routine and staff provided clear explanations to support people's decisions.

Staff respected people's privacy and dignity.

The staff promoted people's independence and encouraged people to do as much for themselves as possible.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People's needs were assessed before they moved into the service. People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when people's needs changed.

People knew how to complain and people's views were listened to and acted on.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focussed on people. The acting manager operated an 'open door 'policy, welcomed people and staff's suggestions for improvement.

The service sought feedback from people and their representatives and staff about the overall quality of the service.

There was a system of quality assurance in place. The acting manager carried out audits to identify where improvements to the service could be made.

Beechtree House Limited

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.

This unannounced inspection was carried out on 19th and 20th January 2015 by two inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of food and catering management.

This inspection was carried out in response to concerns that had been raised with us. We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered the information during our inspection. We looked at records relating to people's care, staff management and quality of service. We reviewed our previous inspection reports. We consulted the local authority safeguarding team, a local authority case manager who oversaw people's care in the service and a district nurse who visited people regularly to provide treatment. We obtained their feedback about their experience of the service. We looked at people's assessments of needs and care plans and made observations to check that their care and treatment was delivered accordingly. We looked at satisfaction surveys that had been carried out.

We spoke with ten people, four relatives, the provider, the acting manager, the deputy manager, and seven members of staff. Not all the people who lived at Beechtree House were able to communicate verbally with us. Therefore, we used the Short Observational Framework for Inspection (SOFI), to capture the experiences of people who may not be able to express this for themselves. SOFI is a way to observing care to help us understand people's experience.

At our last inspection on 21 May 2013 no concerns were found.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said "This is a safe place to be in" and, "The staff make sure we are safe". A relative told us, "We do not have any concerns about our family member's safety".

There were sufficient staff on duty to meet people's needs. There were four members of care staff on duty during the day, including a senior care worker. There was a person responsible for the maintenance of the building, a laundry assistant and housekeeping assistant on duty five days a week. The chef worked full time 6 days a week. Two care workers stayed awake during each night to provide care and support to people. We asked the staff whether there was enough staff on duty. They said, "There are enough of us really as our residents do not have complex needs and most can mobilise independently" and, "We are at our busiest in the mornings but we manage well with our numbers". Staff had time to spend supporting people in a way that respected individual needs. One care worker remained in the lounge at all times during the day. This ensured people were safe and able to converse with staff that were available to listen to them and respond. People were supported by staff during activities and assisted if they needed help to move around. The acting manager reviewed the care needs for people whenever their needs changed to determine the staffing levels needed and increased staffing levels accordingly. This ensured there were enough staff to meet people's needs.

Recruitment procedures included checking employment references and carrying out checks with the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. All staff were subject to a probation period before they became permanent members of staff and to disciplinary procedures if they behaved outside their code of conduct. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Staff training records confirmed that their training in the safeguarding of adults was updated every year. Six members of staff told us that they were aware of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. The service's policy on safeguarding was current and had been updated in September 2014. One member of staff told us, "If we have any concerns about a resident's safety we must speak up and follow the guidance". The acting manager had attended safeguarding meetings and appropriate action taken was consistent with the service's policy.

The provider ensured that the premises were maintained safely and securely. Appropriate windows restrictors were in place to ensure people's access to windows was safe. Radiators were boxed in to protect people's skin from heat. Daily checks of people's call bells were carried out to ensure they were safe to use. People's portable electrical appliances were checked yearly for their safety. People accessed upper floors using two passenger lifts that were maintained and in good working order. Fire escape routes and fire exits were clearly labelled and displayed.

There was a system in place to manage accidents and incidents. These were recorded appropriately and brought to the attention of the acting manager and deputy manager without delay. The acting manager analysed the records every two weeks to check whether common triggers could be identified so that any lessons could be learnt and minimise further risks. People's care plans included risk assessments that were centred on the needs of the individual. These assessments were reviewed monthly or as soon as an incident took place. Each risk assessment included clear measures to reduce the risks and appropriate guidance for staff to follow. A person who had fallen twice in one week was being monitored by staff at all times and was provided with specialised equipment to assist their mobility. Another risk assessment about a person declining to take their medicines contained clear instructions to staff about how to respect their wishes and monitor the situation and alert the GP when necessary. This confirmed that assessed risks to individuals were managed and reduced so that people were protected.

People's medicines were managed so that they received them safely. The provider held a policy for the administration of medicines that was regularly reviewed and current. There was an arrangement with the local pharmacy to deliver the medicines that people needed in pre-packed containers. All medicines including those that were prescribed 'as required' were kept securely and at the correct temperature to ensure that they remained fit for use. Two senior care workers in charge of the

Good

Is the service safe?

administration of medicines checked all new medicines upon arrival. This ensured that supplies were correct and sufficient in meeting people's needs. We observed the administration of medicines during a medicines round. The senior care workers followed requirements as indicated in people's individual Medication Administration Records (MAR) and signed to evidence the medicines had been taken. The MAR sheets were completed accurately and no errors relevant to medicines had been noted in the last twelve months. As the staff followed correct procedures, people were confident that their needs for medicines were met safely.

People lived in an environment which was cleaned daily. Bedrooms, bathrooms and toilets were clean and were free from odour. Most flooring in the service had been replaced. All shared areas were clean and welcoming, although the carpet in the lounge released an unpleasant odour. We discussed this with the owner and acting manager who told us that this carpet was next to be replaced as cleaning was no longer sufficient to remove the odour that was embedded in its fabric.

The provider held a policy on infection control and practice that followed Department of Health guidelines on how to reduce the risk from infection. The acting manager told us they were in process of selecting a member of staff to be the lead in infection control. Staff used hand sanitizers and appropriate hand-washing facilities were available and were regularly used. Staff encouraged people to wash their hands after using the toilet and before meals. Protective Personal Equipment (PPE) such as gloves and aprons were readily available and staff wore PPE when appropriate. Staff changed their gloves after each task. Staff had a thorough understanding of infection control practice and took measures to ensure that the service was clean and free from the risk of infection.

Cleaning schedules that allocated cleaning duties for staff every day of the week were completed. Housekeeping staff were cleaning surfaces and vacuuming throughout the day. One person told us, "In my previous profession I was a healthcare professional and cleanliness, hygiene and safety are very important to me. This place is fine". As the staff took necessary precautions, the risk of cross infection was reduced.

There were individual emergency evacuation plans for people. This was to ensure each person's mobility and behavioural needs could be taken into consideration in case of emergencies. Fire regulation checks were carried out and monitored to ensure people's safety in case of emergencies. These included daily checks of fire doors and emergency exits and weekly checks of the fire alarm, fire equipment, and of each bedroom to identify any fire hazard. Staff knew what to do in case of emergencies. All fire protection equipment was regularly serviced and maintained. The premises were last inspected by an external fire protection service in October 2014 and no concerns were found.

Requires improvement

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs. One person told us, "The staff understand what I need because they know me well". One relative said, "One thing the staff do particularly well is talking with the residents and listen to what they have to say, they don't just do lip service".

Staff had not received all essential training to support people and their individual needs. The acting manager told us, "All the staff's training certificates were missing when I took over the manager's post and we have requested copies to evidence that the training that was attended has taken place". The certificates were not available during our inspection. We were assured that training in the safeguarding of adults and the principles of the Mental Capacity Act 2005 (MCA), the administration of medicines and health and safety had been completed. The staff we interviewed told us that they had received this training and demonstrated their knowledge. However, there were gaps in staff training regarding fire safety, first aid, infection control, food hygiene and manual handling. Measures were in place to ensure only the staff that had received appropriate training were delivering relevant care. For example, only the staff who had completed manual handling training carried out relevant tasks. The acting manager had identified the need for all staff training to be completed and had scheduled most of it for February 2015. We have made a recommendation about this.

Additional training was provided to all staff on falls prevention, and to some of the staff on dementia care awareness, end of life care, diabetes, person centred approaches and behaviour that challenge. The acting manager told us, "Once the essential training has been fully attended, all the staff will be encouraged to attend more of this additional training relevant to their duties". Staff confirmed they had received a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. Staff were encouraged to study and gain qualifications such as diplomas in health and social care.

The acting manager observed staff during their practice every three months. They told us, "If I find a member of staff is not doing something correctly, this is instantly put right and discussed afterward in a one-to-one session". There were disciplinary procedures in place for staff who may behave outside their code of conduct.

All members of care staff received one to one supervision sessions every three months and were scheduled for an annual appraisal. Two members of staff told us, "Supervision is very useful we can discuss anything" and, "We discuss any concerns, my needs for training and what I want to study". A member of staff who had been promoted told us, "I got good support and supervision from the management".

Staff used their understanding of each person to communicate with them in a way that helped them to understand and respond. For example, staff communicated with a person who had not spoken for several years by maintaining eye contact, using pictorial aids and presenting simple options. These measures were included in the person's communication care plan and followed by staff. Staff who sat with people in the lounge initiated and maintained conversations with them to stimulate their engagement. One person told us, "I am a bit of a chatterbox and they (the staff) do well keeping up with me".

Updated information concerning people's welfare were appropriately communicated between staff at handover to ensure continuity of care. For example, records showed that staff were made aware of an incident and of a GP having been called when a person was unwell. There were three handovers between shifts in a 24 hour period and the staff used a communication book to inform next shifts about people's appointments or outings.

People's needs were met by adaptations to the environment of the service. The building was adapted to provide spacious bedrooms, bathrooms and communal areas. There were no private areas where people could converse with visitors due to lack of available space. However people told us, "If my family visit, we either go in my room or talk in the dining room when it is empty, or go out". There was a patio area with a few tables and chairs and a small garden. A member of staff told us, "We only use this in the summer to have barbeques or some meals outside and there is an outside platform lift for people to manage the slope". There were pictorial signs to help people find their way around.

Requires improvement

Is the service effective?

The building was a period property and the fabric of the building showed signs of wear and tear. For example, skirting boards and door frames were chipped and discoloured. The kitchen walls were in need of re-decoration. The front gate was in a state of disrepair. A relative told us, "This is a good home and there have been a lot of improvements but the building is still quite tatty and old-looking". One person told us, "We are used to the place, but how it looks is even more important because there is not a garden we can step out in". A front room on the ground floor that was affected by dampness was vacant and used as a temporary storage room. We discussed the outstanding improvements with the owner and acting manager and were assured these issues were included in their maintenance plan. Workers had been booked and scheduled to address the dampness in the front room. Floorings had been replaced and the dining room and bedrooms had been redecorated. The owner told us, "Maintenance work is ongoing".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the acting manager and the deputy manager who demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. They told us, "We carry out mental capacity assessments to check that people can make decisions such as self-medicating, signing records, or going outside unaccompanied" and "We complete a checklist before we consider whether an application for a person's deprivation of liberty is appropriate". The acting manager held meetings in people's best interest when necessary. The acting manager had sought advice from the DoLS office for people who wished to leave the premises unaccompanied. One person who had been assessed as having the relevant mental capacity was going out every day without restrictions. The acting manager told us, "We have reached an agreement with this person where we are given notice of his expected return so we can ensure he remains safe". No one was subject to DoLS at the time of our inspection.

All staff were trained in the principles of the MCA and DoLS and were knowledgeable about the requirements of the legislation. Two members of staff described to us the circumstances in which an application for DoLS should be made. This showed us staff knew what the legal requirements were in situations where it had been deemed necessary to restrict someone's freedom.

Staff sought and obtained people's consent before they helped them. When people declined, for example when they did not wish to get up or join others in the lounge, staff checked again a short while later to make sure people had not changed their mind. This ensured people's rights to consent or decline were respected. One person told us, "The staff never do anything I don't want them to, they are very respectful".

People were very complimentary of the food that was provided. They told us, "It is always very lovely food", "Fantastic food, everyday it is made from scratch and tastes delicious", "The beef cobbler the other day was superb and there are many of us that look forward to roasts on Sunday lunch" and, "I have eaten it all it was so very good". The chef had consulted people to ensure they were satisfied. She told us of her plans to bring more creativity with the menus while respecting people's traditional taste. On the day of our inspection, the chef had prepared home-made fishcakes. The food was well presented, hot and in sufficient amounts. A member of staff told us, "Working at lunchtime is really enjoyable because people are so pleased, just look at all the food they eat, there is very little left and they all smile more at lunch and afterwards". Visitors were welcome to join their relatives at mealtimes. A relative told us, "The food is truly excellent here".

Menus were discussed every week with people and were displayed for people. Staff reminded people of their choice and offered an alternative if they had changed their mind. People were offered home-made biscuits and hot or cold drinks throughout the day. People's birthdays were celebrated with themed birthday cakes.

People's weight was monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted. For example, a person whose appetite had declined was referred to a GP and their food and fluid intake was recorded daily. Staff knew about people's dietary preferences and restrictions. Specific dietary needs for people who had diabetes or for people who needed a soft diet were respected and

Requires improvement

Is the service effective?

provided for. Staff assisted people to eat when necessary and respected people's pace. A person who needed a diabetic diet told us, "I get my special diet catered for and it tastes great".

Prompt referrals were made to relevant health services when people's needs changed. A person whose behaviour challenged was referred to a specialist nurse in the community psychiatric team, and another person had been referred to an occupational therapist. District nurses visited to assist one person who needed dressings for their skin. A chiropodist visited the service every six weeks and an optician visited every six months. Vaccination against influenza was carried out when people or their legal representatives had provided their consent. These arrangements ensured people were supported to maintain good health and receive ongoing healthcare support.

We recommend that the service finds out more about training for all staff, based on current best practice, in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. Two people said, "The staff are very kind and friendly" and, "Everyone is part of a good bunch here". Two relatives said, "The staff are very patient and treat everyone with respect" and, "This is a caring home".

During our inspection we spent time in the shared areas to observe how people and staff interacted. There was friendly interaction between people and staff and staff responded positively and warmly to people. Staff called people by their preferred names. Some people who had difficulties with verbal communication needed time to express themselves. Staff responded to these needs appropriately and spent the time that was needed with people. During a meal time staff were talking with people in the lounge where they had chosen to eat, giving individual attention to people and waiting for their response. People's requests for help were responded without delay by staff. For example, a member of staff noticed a person's needs before they expressed it verbally and escorted the person to the toilet in a timely and dignified way, providing reassurance and gentle encouragement.

People's diverse needs were accommodated. The staff had invited a priest from a local church to visit every two weeks to suit one person's wishes. People were involved in their day-to-day care. They had choice about when to get up and go to bed, what to wear, what to eat, where to go in the service and what to do. People were provided with information about the service, for example they were updated about repairs, re-decoration and staff recruitment at residents meetings. A member of staff said, "We encourage them to speak up and we listen to what they have to say".

Information about how to complain was provided to people and visitors and was displayed in the entrance. The provider told us that a leaflet detailing the service's facilities and the complaint procedure was in process of being designed. The design included a pictorial format to assist people's understanding. The provider showed us a user-friendly website where people could find details of the service. Menus and activities programmes were displayed in a pictorial form in the communal areas. There was a board in the lounge that stated the day, the season and the weather in large pictorial format. People changed it every day with the support of staff. In the entrance, there was a list of the staff with large ticks and crosses to indicate who was on duty. The acting manager told us that recent photographs of staff were in process of being taken and that they would be added to the list so people could identify them better. These forms of communication helped people, especially those who were living with dementia to understand their care and what was happening in the service.

The provider used an independent mental health advocate when necessary. For example, to represent people's views at best interest meetings if they had no other representative. A person who stayed in the service for respite was provided with an advocate when they needed their views represented before they returned home.

The service had a confidentiality policy that was current and had been updated in September 2014. All staff had signed to evidence they were aware of this policy. Staff were reminded of the importance of maintaining confidentiality and discretion as part of their induction and during team meetings. Staff behaved in a discreet manner and followed the guidance in the policy.

People were able to spend private time in their bedrooms when they chose to throughout the day. All staff knocked on people's bedroom doors, announced themselves and waited before entering. People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity.

Personal records included people's individual plan of care, life history, likes and dislikes and preferred daily routines. The staff promoted people's independence and encouraged people to do as much as possible for themselves. People washed and undressed themselves and moved around independently when they were able to. A person was encouraged to go out whenever they wished and the service checked they had their mobile phone before leaving. This was part of their care plan as a need for autonomy had been identified and assessed. One person said, "I try to remain as independent as I can and the staff understand this, they still make sure I am OK though and come to help if I can't manage".

Practical action had been taken by staff to relieve people's discomfort when a person who approached the end of their life had been referred to a local hospice palliative team for

Good

Is the service caring?

prompt additional support. Specific equipment had been ordered for them to keep them comfortable and as pain-free as possible. A member of staff told us, “We make sure people are comfortable and supported until the end”.

Good

Is the service responsive?

Our findings

Two relatives told us, "We get invited to come when they review our Mum's care so we can have a say" and, "They know our Mum well and they listen to her as a person and respect her opinion".

People's needs were assessed before they came into the service. This included needs relevant to their mobility, communication, likes and dislikes and behaviour. The staff were made aware of these assessments to ensure they were knowledgeable about people's particular needs and wishes as soon as they came into the service. The acting manager told us, "People are welcome to visit as often as they like, see the room, and stay for a day and a night to see how they like the home before they confirm their wish to stay".

People's care was planned taking account of their life history, preferences and what was important to them. For example, a person who had wished to be visited by a member of their church and another person who preferred to receive care from only female care workers had care plans that reflected their wishes. The acting manager told us, "We respond to what people want us to provide and each person has different needs and different preferences so we have to listen". Staff consulted people's care plans. A member of staff told us, "We read care plans but most importantly we get to know each one of the residents well as we spent many hours with them and we listen about their life experiences". A person chose to wear bracelets with jingle bells on and the staff told us, "This makes her happy, this is what she likes to wear". A person chose to remain in bed until lunch and staff respected their wish. People who smoked tobacco were able to do so safely. This ensured staff were aware of people's individualities and responded to them.

People lived in a personalised environment where they were encouraged to express their individuality. People's photographs were displayed on their bedroom doors. People were encouraged to bring articles of furniture from their previous home, to choose furnishings and bedding and display their chosen framed pictures on the walls. Furnishings reflected people's personality, preference and taste. A person's room had been re-decorated at their request and in the colour of her choice. Two people had a telephone installed in their room at their request.

People's individual assessments and care plans were reviewed monthly and updated when their needs had changed. A care plan had been updated when a person's mobility had decreased to include recommendations of additional one-to-one support from staff. Another person's care plan reflected their specific dietary needs and instructed the staff to monitor their food and fluid intake. Another care plan had been updated to reflect an assessment of their need for reassurance when they experienced anxiety. These recommendations were followed in practice as staff were providing this support. This showed that people's care plans were updated and people's health and emotional needs were met in practice responding to people's changing needs.

People's relatives or legal representatives were invited to participate in annual reviews of their care plans and were contacted when there were significant updates. A relative told us, "We are kept informed when things change and are given notice of the reviews".

The provider had a complaints policy and procedure. People were aware of the complaint procedures to follow. One person told us, "If I have a problem I know who to talk to". No complaint had been received in the 12 months before our inspection.

People's views were sought and acted on. Residents' meetings were held every two months and people were invited and encouraged to voice their opinion and suggestions on the food, the staff, the environment and any other topics of their choice. At the last meeting, people had requested specific dishes be introduced on the menus and this had been done. A person had requested windows to be closed in their bedroom and this wish had been respected and noted by all staff. Some people had expressed the wish for more activities and outings. The acting manager had explained to people that this would be improved once an activities co-ordinator was recruited and that in the meantime, two members of staff were available daily to entertain people in the home with activities of their choice. A person told us, "This answered my question".

There was no activities co-ordinator in post. This vacancy was advertised and the acting manager was interviewing candidates at the time of our inspection. However, staff were entertaining people in the afternoons engaging them in activities such as art and crafts, skittles, quizzes, reminiscence and memory games. A 'keep fit person' came once every two weeks to engage people in keep-fit games

Good

Is the service responsive?

and gentle exercise. People told us, "This is great fun". A member of staff played a board game with a person and another was supporting four people when they painted art work. Some of people's art work was displayed in the entrance. Other people chose to listen to music in their rooms or watch television in the lounge. The chef had involved people who wished to bake cakes and biscuits. The chef told us people had enjoyed this activity and planned to make it a regular occurrence. There was an appropriate supply of books, movies and music tapes. People told us, "It can be a bit boring, especially in the morning, once we have read our papers, but staff do provide some things to do and they talk with us so we discuss what we have read in the papers and have good conversations", "There is too much sitting around" and "A few good magazines would be great, like some good sport magazines for the men". We discussed this with the acting manager who told us, "We need more going on and an improved activities and outings programme will be implemented as soon as an activities co-ordinator is recruited". The acting manager assured us that magazines would be purchased to respond to people's wishes.

Good

Is the service well-led?

Our findings

The feedback of people's relatives was sought at people's care plan review and when they visited the home. The provider sent annual questionnaires to people's relatives or representatives to gather their feedback. The last survey was dated May 2014; ten relatives had completed and returned questionnaires. The comments were positive and included, "Quality of the care is the most impressive aspect of the home", "The staff are always friendly and they genuinely care", "The best thing you do is helping protect my Mum", "Outstanding food". Some comments were less positive about the fabric and decoration of the building and the activities. The acting manager had analysed the results of the surveys and had used these concerns to inform their on-going improvement plan.

Our observations and discussions with people, their relatives and staff showed us that there was an open and positive culture that focussed on people. Two people told us, "We can talk with the manager, she is very nice and listens to us" and "The people in the office are kind and we can always go in and talk with them". The acting manager and deputy manager told us, "We have an open door policy"; "We work well together and communicate well". People and members of staff were welcome to come into the office to speak with the management team at any time and we saw that they approached them in the office several times during the day.

Members of staff confirmed they were aware of the service's whistleblowing policy and that they were able to report any concern they or the people may have to the acting manager or deputy manager. They told us that they had confidence in their response. Staff told us, "The new manager and the deputy manager are approachable" and, "The new manager is very receptive and understands what is needed to keep residents and staff happy".

The provider had notified us that the registered manager had left their post in July 2014 and that the interim management of the service was carried out from August 2014 by the deputy manager. An acting manager ensured the management of the service with the support of the deputy manager since 05 November 2014. The registered manager was in process of cancelling their registration with the CQC. The acting manager was in the process of applying to become the new registered manager.

Staff had easy access to the provider's policies and procedures that had been reviewed and updated in September 2014. All staff had signed to evidence that they had read the policies. This system ensured that the staff were aware of procedures to follow and of the standards of work expected of them to provide safe, effective, responsive care and support for people.

The acting manager had implemented changes in the service. This included new templates for people's records and audits to ensure that all care plans and risk assessments were appropriately completed and maintained. The acting manager and deputy manager chaired senior staff meetings and team meetings every two months to discuss the running of the service and invited suggestions from staff about how the service could improve. At the last senior meeting held in October 2014, the acting manager asked, "Would you be happy for your mother to live here and if not why not?". Staff were reminded of good standards of practice, of the importance of respecting confidentiality and people's choice. The acting manager was in the process of improving satisfaction questionnaires to render them more specific to the service.

Audits were carried out to monitor the quality of the service and identify how the service could improve. The acting manager or deputy manager carried out daily checks in the service. They checked all call bells and cleaning equipment were in good working order, checked each bedroom for hazards, and observed correct procedures were practised by staff. Daily environmental checks were carried out to identify and monitor repairs. The person responsible for the maintenance of the home checked that all equipment including wheelchairs was in good order and reported their findings to the acting manager. On the day of our inspection, these checks had identified the need for a new wheelchair battery to be purchased and this was implemented without delay.

The acting manager audited the incidents and accidents log every two weeks to identify any triggers and patterns that may identify how to minimise future risks. One audit had outlined that a person's falls happened early in the mornings and morning medicines had been reviewed to minimise risks of dizziness. The acting manager audited care plans, review documentation and recruitment files to ensure they were appropriately completed and accurate. Medicines Administration Records (MAR) were audited

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Is the service well-led?

monthly. One audit had identified the need for better identification of people on their MAR charts and people's photographs had been added as a result. Audits of infection control and cleanliness of the premises were carried out monthly. An audit identified the need for several toilet seats to be replaced and this had been done. A need for the replacement of flooring in the hallway and a fitted carpet in the lounge had been identified and these improvements were scheduled to take place. The acting manager told us, "There is always room for improvement and we follow our improvement plan".

The acting manager had written a plan to improve aspects of the service. It addressed new documentation to simplify people's records in relation to the planning of their care, research on ways to improve links with the community, the monitoring of staff training and recruitment. They told us, "We are getting there".

The acting manager spoke to us about their philosophy of care for the service. They told us, "Our residents need to feel valued and respected by staff who understand how they may feel. I would like this home to become a model of how good dementia care can be".

The acting manager notified the Care Quality Commission of any significant events that affected people or the service.

Records indicated the acting manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

The office that was shared by the acting manager and deputy manager and that contained documentation relevant to the running of the service did not contain sufficient shelving and was cluttered. This meant that managers may not be able to find and access these records quickly. Plans were in place to re-organise the office and provide additional storage. People's records were stored securely in a dedicated room and staff had full access to these.

Archived records were labelled, dated and stored in a dedicated space. They were kept for the length of time according to requirements and were disposed of safely. All computerised data was password protected to ensure only authorised staff could access these records. The computerised data was backed-up by external systems to ensure vital information about people could be retrieved promptly.