Care Quality Commission

Alpha Care Castlemaine Limited

Castlemaine Care Home

Inspection report

Castlemaine Care Home
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East Sussex
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Ratings

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

Overall summary

Castlemaine Care Home provides residential care for up to 42 older people, living with dementia. As a result of their dementia, some people were at risk of falls and required support with their mobility. The lounge and dining areas were spacious enabling people to walk safely around the home. Some people displayed behaviours that challenged others and all needed support with their personal care. At the time of our inspection there were 32 people living at the home. Accommodation was arranged over two floors and there was a lift to assist people to get to the upper floor.

This was an unannounced inspection, carried out over two days on the 6 and 11 November 2014.

A registered manager was in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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.'

Summary of findings

Although people and relatives told us they felt safe, there had been a high turnover in the staff team. Staff told us that as a result, when there were agency staff on duty routines took longer and this meant that people did not always receive care promptly. There was no tool in place to determine staff levels based on people's needs.

Staff told us that they could raise issues with the management of the home. However, not all staff felt they were listened to and valued. Supervision meetings were rarely held and the results of the staff survey had not been fed back to staff.

The systems to monitor the quality of the home were not effective, as they did not ensure that people received safe care. For example, matters that should have been referred to the local safeguarding team for possible investigation had not been reported. There was no monitoring of the accidents and incidents that occurred in terms of trends or patterns to try to reduce the occurrences.

Visitors to the home told us that they had no problem raising concerns with the management of the home. However, there were mixed responses about whether their concerns would be addressed. One person told us, "I don't find them very responsive when issues are raised." Another person said, "I could tell (managers) if I had a complaint. They would take action. I'd feel confident about doing that."

All staff received training to fulfil the duties of their role and more specialist training was also offered to ensure that staff met the people's complex needs. However, whilst there were systems to ensure staff had knowledge there were limited systems to assess if people had developed appropriate skills to care for people effectively.

There were a number of positive aspects of care at the home. Staff worked closely with healthcare professionals to assist them in meeting the changing health needs of people and where advice was obtained this was included in people's care plans. People's care plans had been reviewed and updated regularly as people's needs changed. Relatives were invited to care plan meetings and management worked closely with them in ensuring that as far as possible, people's end of life wishes were known.

The provider ensured that if someone was admitted to hospital a, 'This is me' document was sent with them. This document provided details of people's medicines and a summarised version of the person's medical history, ability to communicate, individual needs and abilities and behavioural guidelines, (if appropriate). This ensured any staff member caring for the person would have up to date information about the needs of the person.

People were treated with kindness and staff spoke in a reassuring manner. People and visitors told us that the food was good and that they could have alternatives if they did not want what was on the menu. Over mealtimes there was good communication between staff and people and staff checked that each person had enough food and that it was to their liking.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

A local healthcare professional told us that the manager and deputy both attended a local care discussion forum that was held quarterly. The group discussed a range of issues that could have an impact on care provided in care homes. They said that the local group helped the staff team to provide support in a particular speciality area.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in ensuring that staff were appropriately supported, having appropriate systems to deal with safeguarding matters, having proper steps to ensure that people were at risk of receiving care that was inappropriate and not monitoring the quality of the home well enough.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe. Staff had not identified potential safeguards and had not reported incidents that placed people at risk of harm or abuse.

We observed poor moving and handling procedures. Items were left unattended that could have left people at risk of harm.

There was a high use of agency staff which meant that routines took longer to complete as staff had to support agency staff. There were safe recruitment procedures and relevant checks had been completed before staff worked unsupervised at the home.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff rarely attended supervision meetings and did not feel supported in their roles. Staff had received training on the Mental Capacity Act. However, the service was not fully clear about the need to make applications to the Deprivation of Liberty Safeguards team.

A comprehensive training schedule ensured staff had the knowledge necessary to carry out their roles. However, there was no effective system in place to check that staff developed their skills.

Menus were varied and well balanced. People told us and we observed, that they had an alternative meal if something was not to their liking.

Is the service caring?

Requires improvement

The service was not always caring. Relatives were involved in the care planning process and were invited to annual reviews. Care plans were personal and included detailed information about the things that were most important to the individual and how they wanted staff to support them.

Staff communicated clearly with people in a kind and reassuring manner and it was evident that they knew people well and had good relationships with them. We observed that people were treated with respect and dignity.

Is the service responsive?

Requires improvement

The service was not consistently responsive. There were mixed responses to how concerns/complaints were dealt with and some relatives said that improvements were not always sustained.

People's individual care plans provided the information staff needed to enable them to provide personalised care. There were a range of activities that people could choose to participate in but fewer opportunities for those who required one to one support.

Summary of findings

Is the service well-led?

The service was not well-led. Although there were systems to assess the quality of the service provided, these were not effective. Where shortfalls in audits were identified they were not followed up to ensure they had been addressed.

Satisfaction surveys had been sent out but the responses had not been collated and no feedback had been given to the staff, people and visitors.

Accidents and incidents were not monitored to identify any trends or patterns. There was limited written evidence that the owners were monitoring the running of the home.

Inadequate

Castlemaine 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 6 and 11 November 2014 and was unannounced. We last inspected Castlemaine on 15 May 2013. At that time we found the provider was meeting all the essential standards we assessed. However at this inspection we found a number of areas of concern.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE who joined us had specific experience in dementia care.

Before our inspection, we reviewed the information we held about the home. This included notifications of deaths, incidents and accidents that the provider is required to send us by law. Following the inspection we contacted the Commissioners (social services) of the service and two local healthcare professionals to obtain their views about the care provided.

We spoke with the registered manager, four people who used the service, 12 relatives, five care staff, the activity coordinator and the cook. We observed care and support in communal areas and also looked at the kitchen and a number of people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for five people, the staff training and induction records, people's medicine's records and the quality assurance audits that were available. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

Staff told us they felt people were safe and well cared for. However, we found that action was not always taken to ensure people's safety. A staff member told us, "It helps that we know the residents needs well as this helps us know what could cause them stress and put them at risk." Visitors to the home told us that staff knew each individual well, even if they were agency staff. A visitor told us, "The staff seem to know people very well, they know (my relative's) habits, her likes and dislikes." Despite the positive information people gave us we found several areas that were not safe.

Staff had a good understanding of safeguarding and what actions to take if they suspected abuse. One told us, "It's the most important reason I am here, to keep everyone safe." Another told us, "I would report anything I was concerned about to the management and if no action was taken contact the CQC or the Local Authority." Staff training records confirmed staff had received training in safeguarding adults at risk and this training was refreshed six monthly. However, we looked at records for accident and incidents for a one month period. Details of the actions taken were not always clear. For example, there were two accidents where people sustained head injuries and it was not evident that medical attention had been sought. There were also two recent incidents where there had been arguments between two people that had resulted in physical harm. Neither of these two incidents had been referred to the local safeguarding team for possible investigation. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection it was noted that equipment that could have caused harm was left unattended on a window sill for the majority of a morning. People wandered around the room and could have been at risk of harm. This was brought to the attention of staff and the matter was addressed.

We observed poor moving and handling practices. One person was supported to move from a chair to a wheelchair using a transfer belt and two staff. Whilst the move was successfully implemented, staff had not left enough room to complete the transfer and the manoeuvre was clumsy with a potential risk of the person falling and staff injuring their backs. On another occasion we observed staff supporting a person to move from a wheelchair to a chair. Staff used an underarm lift to assist the move. Underarm lifts are no longer considered an acceptable way to move people safely as they can result to damage to the spine, shoulders, wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. These areas were breaches of Regulation 9 of the Health and Social Care Act 2008.

There had been a turnover in the staff team which had led to the regular use of agency staff. Staff raised concerns about this and the impact this had on them and on people. An example given was, "Agency staff often do not know the residents or the routines and this means we have to work harder and it is more stressful." Another told us, "The staff levels are usually the correct numbers but when you have more than one agency staff on duty it can up the risk of things being missed." Whilst we saw staff were busy we did not see this impact on the safety of people. A visitor told us, "There seem to be a lot of agency staff, sometimes only for one day, but they seem to get on well with the patients."

Two staff told us they felt the early shift needed one extra care worker on duty to manage the volume of work safely. We asked staff if they had raised these issues with the home's management and three of the five staff told us they had. We spoke with the management team about this and they told us they were actively recruiting to fill permanent care worker vacancies. The rotas confirmed the home did not go below what they had stated were safe staff levels. However, at times there was a high use of agency staff. Minutes of a management meeting held in October 2014 demonstrated the owners had given permission to increase staff levels if needs dictated. However, there was no formal assessment tool in place to determine the numbers of staff needed to meet people's assessed needs and neither the owner nor the manager was able to confirm how many actual hours needed to be filled to complete the staff compliment.

Due to the high use of agency staff the home had taken measures to ensure that agency staff were clear about how the home operated. Agency staff signed an agency orientation sheet, this was to confirm that they had read the home's agency induction folder and confirmed that they had been given a tour of the home. Staff had been given clear advice on how to gain support should this be necessary outside of normal office hours. There were clear

Requires improvement

Is the service safe?

on-call arrangements in the evenings, at weekends and for emergencies. In addition to local on-call procedures, there were procedures in place to call external management in the event of an emergency.

Staff told us they had received medication training and an annual competency check had been completed to ensure they continued to follow the agreed procedures. Medicines were stored appropriately and there were systems in place to manage medicines safely. Stock checks were completed when medicines were delivered to the home to ensure people received their medicines as prescribed. We were told that one person sometimes received their medicines covertly. Staff told us that this had been agreed with the person's GP in their best interest. However, staff could not locate written evidence of this instruction. Without the correct documentation in place staff have a duty to tell the person what they are giving them and to provide them with the opportunity to refuse their medicine.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. Staff files confirmed that staff had completed an application form, references were obtained and forms of identification were present. Criminal records checks had taken place. This showed us that the provider had checked that people had no record of misconduct or crimes that could affect their suitability to work with people.

Some people displayed behaviours that challenged. Where this was the case their care records identified how this may present. One staff told us, they had training on how to deal with difficult situations." During our inspection there were incidents where people displayed behaviours that were challenging for staff and they were managed in a safe and sensitive manner. Staff spoke calmly, reassured people and provided alternatives for them. One incident was the result of there being only one toilet facility available on the ground floor and one person did not want to wait. The second toilet facility was temporarily out of order. Whilst the situation was handled well the facility had been out of order for a period of time on both days of our inspection and this had an impact on people. Staff also had to support people to take them to their rooms to use their ensuite facilities.

Risks to people were assessed and reviewed. Risk assessments included, falls risk assessment, moving and handling, and a room risk assessment. Individual risk assessments were based on people's specific needs, for example a risk had been assessed for person who had displayed signs of self-harm. Staff were aware of where to find people's risk assessments. Senior care staff were aware that risk assessments were required to be reviewed and updated regularly.

Requires improvement

Is the service effective?

Our findings

At lunch time we observed four people who were supported with their meals by care staff. Staff supported them effectively by sitting at the same level, giving them good eye contact and engaging positively with them throughout the mealtime. The meal service was relaxed, organised and well-paced for people. One person told us, "We always have a decent lunch – can't complain there. Lunch was very tasty." When people required specialist advice and support this was arranged. Relative's views were included as part of care planning. Although we observed areas of care that were effective we also found areas of practice that were not.

Staff told us they did not have supervision regularly. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Most staff said they had not had supervision for over a year. One member of staff told us that they had to request supervision. We asked staff how they raised issues with senior staff, they told us they may discuss things in team meetings or go into the manager's office. However, staff meetings were not held regularly. One staff member told us, "I don't really feel I am listened to or taken seriously, I don't think what I say is taken notice of." We checked supervision records and confirmed that staff did not have the opportunity to attend supervision meetings in line with the provider's policy. There was no system in place to provide an annual appraisal of staff performance. The provider had not given staff suitable opportunities to express concerns and consider their training and therefore staff may not have had the training necessary to deliver care effectively. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was knowledgeable about the Mental Capacity Act 2005 (MCA) and how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. Within care plans the principles of the MCA Code of Practice had been used when assessing an individual's ability to make specific decisions. Staff had a good understanding of the subject.

In March 2014, changes were made by a court ruling to the Deprivation Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The manager told us that no one living at the home at the time of inspection required an application to be made under the Deprivation of Liberty Safeguards (DoLS). She said that there was no one who was subject to a level of supervision and control that may amount to a deprivation of their liberty. However, our observations during the inspection led us to believe that people were deprived of their liberty. For example, on the first floor we found a person trying to get through a keypad locked door. They had gone upstairs to spend time in their room and had not been able to get back down. It was not known how long they had been there or how long they would have remained there if we had not found them. We also observed a staff member supporting a person to use the garden area. It was noted that whenever anyone else attempted to go through the door they were redirected by staff to another area. We discussed DoLS with the manager who did not have a comprehensive understanding of the legislation and therefore people were at risk of being deprived of their liberty unlawfully. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was an annual training plan which identified when training was scheduled to take place. This showed staff had regular opportunities to undertake a range of training. The majority of staff had undertaken recent training on health and safety, infection control, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff completed training in moving and handling and safeguarding on a six monthly basis. Staff told us that they attended training regularly. One told us, "There is training pretty often which we are expected to attend." Given that staff had recently received training on DoLS it was not evident that the training received had been effective. In addition, although there was six monthly training on moving and handling it was not evident that the training provided had effectively met staff's needs.

Specialist training had been arranged by the manager for staff to develop their skills and knowledge in dementia. For example, all of the staff team had attended training on dementia in January 2014. Three staff had also attended a more in-depth course on dementia. Staff told us that the training they received was sufficient to meet their needs.

Requires improvement

Is the service effective?

Staff induction consisted of a one day training and orientation with a senior staff member, followed by up to three days shadowing care staff. Staff told us that the induction process had been sufficient for them. One staff member told us, "My induction was fine; I had a lot of experience in care before I came here." Staff had signed to state that they had completed induction and that they had read the home's key policies. In addition to the home's induction, staff also completed a more detailed 12 week induction. By the end of this process staff had a good understanding of how to meet the needs of people living at Castlemaine.

On our arrival we observed some people having their breakfast. People had been offered a choice and specific requests were accommodated. Staff regularly offered people a choice of hot and cold drinks through the day.

The majority of people had their lunch in the large joint dining and lounge area. Some people sat at tables and others used tray tables. The meal service was relaxed, organised and well-paced for people. People told us they were happy with the food and they ate well. People who were not being supported with their meals were not reminded what they had asked for when they were served.

One person told us, "The food is always hot and fresh, I am happy." The chef told us they felt well supported to deliver a varied menu which catered for people's individual needs. They also catered for specific diets such as diabetic, low fat and fortified. They told us that senior staff notified the kitchen if someone's dietary needs changed, for example if a person required a pureed diet. There was a choice of two main meals available and the chef or the kitchen assistant took people's orders for food when they came onto shift. The chef told us, "We can always ensure people get what they want or fancy to eat." One person did not eat their meal. Staff prompted the person and when they still refused their meal they offered them an alternative which was then provided and eaten.

Food and fluid charts were kept to record what people ate and drank to ensure that they received appropriate hydration and nutrition. Where there were concerns about a person's nutrition, a referral was made to the person's GP who made arrangements for a speech and language therapy (SALT) assessment. (SALT teams provide advice and guidance for people who have difficulty with eating, drinking and swallowing). It was noted that where this was the case the advice obtained was included in people's care plans. For example, some people required a pureed diet and others required thickened drinks.

Visitors told us they were involved in the reviews of their family member's care plans and were happy with their level of involvement. People's needs had been assessed and a plan of care developed to meet them. Detailed information was provided to support each person with all aspects of their daily living skills and individual preferences. For example, one person wanted an easy reach bedside light.

Staff had worked closely with healthcare professionals to assist them in meeting the changing health needs of people. For example, one person had received support from the local speech and language team. The advice obtained was included in the person's care plan and staff were clear about the actions to be taken.

Emergency plans were in place and understood by staff. Each person had a personal evacuation plan which included details about their level of mobility and the allocated place of safety in the event of a fire. The registered manager told us that they or their deputy could be contacted in the event of an emergency. There were clear instructions for staff to follow, so that the disruption to people's care and support was minimised in the event of an emergency situation occurring. This included having a "This is me" document for each person for use out of hours. The document included details of people's medicines and a summarised version of the person's medical history, ability to communicate, individual needs and abilities and behavioural guidelines, if appropriate.

Requires improvement

Is the service caring?

Our findings

People told us that they were looked after well. A relative told us, “The staff are very caring, very good, I can’t fault any of them. Another said, “They always give my relative time to think and give an answer, they’re very respectful.” We were also told, “They put my relative in a wheelchair and take her to the toilet no fuss, it’s all very discreet. I think people’s dignity is kept.” During the inspection we observed and heard staff speaking in a kind and reassuring manner to people living at Castlemaine. Whilst the majority of our observations were positive, a relative told us, “I have made suggestions about people’s dignity (such as trousers undone or people sitting in wet clothing), there’s not always a good response.”

During our inspection people received chiropody treatment. We were told that there was no area set aside to carry out this treatment so it was undertaken in the lounge. Although there were screens available staff did not ensure that they were used. This gave people no dignity. We were also told that hairdressing was also carried out communally in the lounge.

Staff spoke to people in a kind and reassuring manner. We observed kind care delivery by staff, for example, one person liked a particular type of music. When they were feeling stressed, staff played their music and it was noticeable that this helped them to settle. People spoke very highly of the caring and compassionate nature of the staff at Castlemaine. They said that the staff were patient and respectful, and that visitors were always made to feel welcome. For example, one person told us, “The staff are lovely, such hard workers.” A relative told us that their relative, “Is looked after 100% - always nice, clean and tidy. If there’s an accident they are taken away immediately and have fresh clothes.” We observed that when staff helped people with personal care they always made sure that bedroom doors were closed to maintain privacy.

Care plans demonstrated people and their family’s involvement, and each person’s care plan included a life history. People’s personal preferences had been recorded on admission to the home and where possible set out people’s preferences for daily life and for when they reached the end of their life. The manager and deputy manager had completed training in end of life care and had close links with the local hospice. They were keen that people at Castlemaine would be able to end their days in private and with dignity and worked closed with relatives to ensure this happened.

When a person wanted to use the garden area staff supported them to do so and made sure they were warm enough before taking them out. People were dressed appropriately for the season. Some people liked to wear jewellery and staff made sure that this happened.

Relatives and friends were able to visit at any time. On the first day of our inspection there was a steady flow of visitors to the home throughout the day. Staff told us that some visitors often came to the home daily. Visitors told us that if they wanted to they could share a meal with their relatives when they visited. Staff were knowledgeable about the individual needs and abilities of the people they cared for and supported. For example, one person liked to dust shelves at a particular time each day and they were supported to do this.

Requires improvement

Is the service responsive?

Our findings

A wide range of activities were provided for those who could participate in group activities. Time was also spent with people on a one to one basis but record keeping relating to these sessions were not detailed and it was difficult to determine if people enjoyed them. Complaints raised formally were investigated and resolved. However, we found that the home was not always responsive to complaints raised informally.

Everyone said that they had no problem raising concerns but out of eight relatives, four had positive experiences and four had negative experiences. One relative told us, "I don't think they always make sure (my relative) is clean," their "teeth aren't always clean. Small things for personal wellbeing." They said that they had raised these issues with the home manager and were confident about doing this, but less confident that the solution would be maintained. Other comments raised by relatives included, "There's a limited response to suggestions, changes don't always last in how (my relative) is cared for," And, "I don't find them very responsive when issues are raised." On the other hand we also received positive comments such as, "I'd be happy to raise any issues, they've told us that they would rather know so they can put things right, they are very open." Another comment included, "The staff in the office are lovely, you only have to report things once and they deal with it." The above comments meant that concerns raised were dealt with at the time but were not documented. Because of the lack of documentation the whole staff team were not aware, and therefore the solution was not always maintained. The complaint policy was displayed in the entrance lobby. There was only one written complaint. Records demonstrated that a full investigation had been carried out and feedback was given to the complainant.

There were mixed views about the quality of activities provided. A small number of people who had the ability to participate in activities enjoyed a wide range of stimulating activities. Where this was not the case there was limited evidence that people received sufficient stimulation and activity. On the day of our inspection there was a flower arranging session in the morning, which was clearly enjoyed by the people who could take part, and bingo in the afternoon, which again was enjoyed by seven people. This meant however that the majority of the people at Castlemaine either could not, or did not, join in the group activity. Although the home had facilities such as rummage boxes, these were not accessible unless offered by the staff and we did not see them used. Rummage boxes contain objects that can help people with dementia to trigger memories and enhance past skills, hobbies or occupations.

We were told that some people had meaningful activities that they chose to do. One person told us, "My relative likes to polish and tidy and sweep the floor and they are happy doing it." Whilst another relative said, "They need to find my relative a job to do, she says she is bored." One to one activities were provided and records were kept of individual time spent with people. However, this was a missed opportunity to record the work carried out as records were not sufficiently detailed to determine each person's level of engagement and if they had enjoyed the activity. For example, records for one person stated 'shown a variety of flowers for sensory activity.' There was no other information provided.

An activity coordinator was employed to work 25 hours each week and the hours were worked flexibly to meet the needs of people. Visitors spoke highly of the work carried out by the activity coordinator. We were told, "The activity lady is very good, she arranges for dogs and other animals to come in, just terrific." Each month a new activity programme was drawn up which was varied and included a number of group activities and people had the opportunity to participate or opt out of activities as desired. Activities included musical entertainers, weekly canine concern group, a trip out once a month, shopping, arts and crafts and reminiscence groups. The home had recently purchased a 'tablet' to assist people to communicate by video with relatives and friends who were not living close by.

One visitor told us, "I'm involved in my relative's care plan and go to the meetings. I'm happy with the care plan and we have an end of life care plan too for when the time comes." We were present whilst the deputy manager completed a review with relatives of one person. Detailed information was provided and the relatives were asked for their views on a range of matters. The relatives told us that they were very happy with the care provided. One said, "My relative's wellbeing has gone up and up since moving in."

Requires improvement

Is the service responsive?

Visitors told us they had been kept fully informed about any changes in people's health or any incidents. For example, "They rang as soon as there was a problem. They were very open and honest and dealt with it quickly and professionally."

There was some evidence of links with other care homes in the vicinity where they invited people to attend activities in the home and we were told that people were also invited to other home's activities. This had been something the home did regularly in the past and were reinstating. Arrangements had been made for some people from one care home to join a Christmas event that had been arranged.

Staff told us changes to care plans were communicated to them at handover and a message was put in the communication book to read the changed care plan on the computer system. They said that as they complete daily records on the system this means that they have instant access to all records and can respond to people's changed needs. Staff were knowledgeable about people's needs and could tell us about recent changes to care plans.

Inadequate

Is the service well-led?

Our findings

Two relatives told us, that should they need to move into a care home at a future date, they would be happy to move into Castlemaine. One relative said, "If I ever had to come into a home I hope it's one like this." We were told by professionals that the home was well led. Visitors said that they had attended relatives' meetings and were unanimous in their view that the home manager had an open style which welcomed feedback. However, whilst relatives felt that management heard their feedback they were not confident action would always we taken. We also found that the systems to monitor the quality of the service were not effective and actions were not always taken appropriately.

The manager and deputy shared an office by the entrance lobby which meant that they were easily accessible to all visitors, staff and people. Staff, people's relatives and visiting professionals were asked to complete an annual satisfaction survey in June 2014. The response rate was low and had not been collated, therefore no feedback had been given to those who had responded. Whilst a number of positive comments had been received there were also negative comments. For example, a relative had raised concerns about the home's fire evacuation procedures and a staff member had raised concerns regarding care and support provided to people. There was no evidence that these matters had been considered and that anyone had discussed the matters with them. By not collating the feedback received, the provider was unable to evaluate and take action on people's views.

We were told that the provider had full remote access to the home's computer system and that they monitored the home's documentation in this way. The manager told us that the provider visited weekly, that he discussed the running of the home with her, and spent time with people and staff. There were no written records to confirm these visits. There was a record of one meeting held between the owners and the manager and her deputy. A limited number of topics had been discussed but there were no conclusive decisions and no timescales of actions agreed to be implemented. For example, we spoke with the manager who confirmed that two toilets on the ground floor were insufficient to meet people's needs. A discussion had been held with the provider regarding the installation of a wet room and toilet facility but a date had yet to be agreed for this to happen. We observed the impact that this caused when one toilet was out of action for periods of time on both days of our inspection and staff had to support people to other areas of the home to use alternative facilities.

We asked to see records of accidents and incidents that occurred in the home. We were told that we would have to individually log into each person's name on the computer. Managers confirmed that they read all reports as and when accidents/incidents occurred and took actions where appropriate. However, there were no systems to monitor for any trends or patterns and they were unable to provide information about numbers, frequency, time and place of accidents/incidents. On the second day of our inspection the manager had printed a list of all accidents and incidents for a one month period. We were told the provider had given them additional computer training which meant they now knew how to use the computer more effectively and would be able to obtain information more readily to help them analyse accidents and incidents.

There were systems to monitor the quality of the home but these were not carried out on a regular basis and it was not always evident that matters raised had been addressed. For example the issue of torn lino in the dining room had been raised in September 2013 and again in February 2014. In February 2014 it was stated that this would be addressed within three months. However, this had yet to be done. The information in the above four paragraphs are a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked to see the policies on safeguarding adults at risk and whistleblowing. The policies were difficult to locate as the safeguarding policy was known as 'reporting bad practice' and there was no reference to the word safeguarding in the document. The flow chart in place stated that the manager would investigate any bad practice and there was no reference to the need to refer allegations of abuse to Social Services who have lead responsibility for all investigations. This might account for the fact that matters noted under the 'safe domain' had not been reported. Within the whistle blowing policy, there was no reference to whistle blowing within the procedure and, no information about the workers' rights to protection. Policies should be easily located and should ensure that staff are provided with clear information about actions to take.

Inadequate

Is the service well-led?

The manager was not clear about the home's vision and values and therefore it was difficult for staff to deliver against the home's values in everyday practice. One staff member told us, "I know I can always go in and talk to the manager." However, another staff member said that they did not feel very positive about the home at the moment and were quite stressed due to the low numbers of permanent staff.

As a result of the staff shortages, morale was low amongst staff. Staff did not receive regular supervision to share their views or say how they felt. Staff meetings were infrequent so did not provide regular opportunities for management to spend time with staff hearing their views on the running of the home. Whilst management offices were at the entrance to the home and therefore readily accessible to visitors, they were slightly less visible to the staff team.

There was limited evidence that management met regularly with staff to hear their views. Three staff meetings had been held with night staff this year. Two meetings had been held with senior staff in June 2014. Staff meetings are an opportunity to discuss changes in care practices and to ensure that all staff receive consistent advice and support at the same time. Given the turnover in the staff team and the fact that individual supervision was not provided to staff, the lack of staff meetings combined with the lack of supervision meant that there was very little opportunity to provide updates and to hear staff views on the running of the home.

Two resident's meetings had been held, in January and June 2014. The activity coordinator said that they wanted to increase the frequency of meetings. Minutes showed that activities and menus had been discussed and that people had raised suggestions. For example, one person had asked to have curry and this had been added to the menu.

The provider was proud of their links with their local community. A local healthcare professional told us that the manager and deputy both attended a local care home manager's discussion forum that was held quarterly. The group discussed a range of issues that could have an impact on care provided in care homes. They said that the local group helped the staff team to provide support in a speciality area. We observed the deputy manager exploring this topic with relatives of a person and saw that the topic had been raised within care plans and relative's preferences had been sought.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not always take proper steps to ensure that people were at risk of receiving care that was inappropriate. **Regulation 9** (1) (b) (i) (ii) (iii) (iv)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have an effective system in place to regularly monitor the quality of care provided. **Regulation 10**(1)(a)(b)(2)(b)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person failed to respond appropriately to safeguarding matters. **Regulation 11(1)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. **Regulation 18(1)(2)(e)**
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person failed to ensure that there were suitable arrangements in place to provide supervision and appraisal for staff. **Regulation 23(1)(a).**