Ashdown Care Limited

Ashdowne Care Centre

Inspection report

Orkney Mews
Pinnex Moor Road
Tiverton
Devon
EX16 6SJ

Tel: 01884252527
Website: www.halcyoncare.co.uk

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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

Summary of findings

Overall summary

This inspection took place on 20 and 21 April 2016 and was unannounced. Ashdowne Care Centre is registered to provide accommodation with nursing or personal care, for up to 60 people. The service is intended for older people, who may have a dementia or mental health need. The home is divided into two units, Ashdowne and Pinnexmoor. Each of these units has its own staff team. The two units are joined by a linked corridor. There were 48 people living at the home at the time of our visit.

We last visited the service in August 2015 to undertake a focused inspection. This visit was to look at actions taken by the provider to address concerns found at a comprehensive inspection in March 2015. There had been significant improvements to the overall management of the home. All legal requirements had been met.

The service had two registered managers in post who shared the role. The second registered manager had moved from another of the provider's locations in February 2016. A registered manager is a person who has registered with 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.

There were adequate staffing levels to meet people's needs. Staff had clear leadership roles at the home with delegated responsibilities.

People were supported by staff who had the required recruitment checks in place. Staff had received an induction and were knowledgeable about the signs of abuse and how to report concerns.

The provider had not ensured all staff had undertaken mandatory training to ensure they had the required knowledge to meet people's needs. Not all staff had received support with their practice through supervisions and appraisals.

People were involved in making day to day decisions. Staff delivered care that was kind and compassionate. People felt they were treated with dignity and respect.
Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed on people's behalf.

Care plans were personalised and recognised people's health, social and psychological needs. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The premises were well managed to keep people safe. A designated maintenance person was employed to undertake repairs and undertake regular checks of the service. There were emergency plans in place to protect people in the event of a fire or emergency.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. People were happy they could raise a concern if they needed to and action would be taken.

The provider actively sought the views of people, their relatives and staff through staff and residents meetings and questionnaires to continuously improve the service.

We found a breach of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines in a safe way with the exception of some topical creams.

People were supported by enough staff so they could receive care and support as needed.

The provider had robust recruitment processes in place.

Staff were knowledgeable about the signs of abuse and were confident action would be taken if they raised a concern.

People's risks were assessed and actions taken to reduce them as much as possible.

Accidents and incidents were reported and action was taken to reduce the risks of recurrence

The premises and equipment were managed to keep people safe.

Is the service effective?

Requires Improvement

One area of the service was not always effective.

Not all staff had received training and regular supervisions.

The registered manager and staff had an understanding of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People were supported to eat and drink and had adequate nutrition to meet their needs.

People had access to on-going healthcare support and their health needs were assessed and care plans implemented.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate towards people, and had warm and caring relationships with them.

Staff supported and involved people to communicate and express their views.

Visitors were made welcome and could visit at times to suit all concerned.

Is the service responsive?

Good

The service was responsive.

Care was personalised, staff knew people well, and cared for them as individuals.

People had their individual needs regularly assessed, recorded and reviewed.

People knew how to raise a concern or complaint and were confident they would be dealt with appropriately.

People were supported to take part in social activities. Activities were in place to ensure people were not at risk of social isolation.

Is the service well-led?

Good

The service was well led.

There were two registered managers at the service. The staff had a good understanding of their roles and responsibilities.

People, relatives and staff expressed confidence in the management and said the home was well organised and run.

People, relatives' and staff views were sought and taken into account in how the service was run and suggestions for improvement were implemented.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

Ashdowne Care Centre

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 was 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 20 and 21 April 2016 and was unannounced. On the first day of our visit two inspectors visited the service. On the second day of our visit two inspectors were accompanied by an expert-by-experience. An expert-by-experience is a person who has personal experience of this type of care service; they had experience of services for people with mental health needs.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from 24 people who were able to tell us about their experiences. We also spoke with ten visitors to ask their views about the service. The majority of people staying at the Pinnexmoor unit were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to help us understand their experiences. These methods included both formal and informal observation throughout the inspection. 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. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke and sought feedback from 14 staff, including the Ashdowne unit lead, two registered nurses, care workers, catering and housekeeping staff, the maintenance person and the administrator. We also spoke with both of the registered managers and the provider's representative referred at the service as the operations manager.

We reviewed information about people's care and how the service was managed. These included five people's care records and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits, minutes of team meetings and comments from cards people and relatives had completed. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from one of them.

Good

Is the service safe?

Our findings

People and visitors said they felt the service was safe. One person said , "I don't feel frightened of them, sometimes I want them in a hurry and they come." Another said when, "Oh yes I feel very safe."

People received their medicines safely and on time with the exception of some prescribed topical creams. This was because topical cream records had not always been completed on the Pinnexmoor unit. However they were accurately recorded on the Ashdowne unit. This meant the nurses could not be sure if prescribed creams had been applied as prescribed or whether staff had forgotten to record their use. The management team said they were confident people had their prescribed creams applied and felt it was a recording issue which they would address.

All medicines were administered by nurses whose competencies had been assessed by senior management. Nurses were seen administering medicines in a safe way. They had a good understanding of the medicines they were giving out. People said they were given their medication and creams were applied as necessary and they were happy with their treatment.

Where people had medicines prescribed as needed, (known as PRN), protocols were not in place about when and how they should be used. The local pharmacist had discussed this with the registered manager and supplied some suitable documents. On our second visit these were being put into place by the registered nurses.

There was a system in place to monitor the receipt and disposal of people's medicines. Medicines which required refrigeration were stored at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the registered manager and action had been taken to ensure people had received their medicines. Audits of medicines were completed by the registered manager and records showed actions were taken to address issues identified.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS) and appropriate references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. A new staff member confirmed they had not been able to start work at the home until they had a DBS and two satisfactory references in place.

Our observations and discussions with people and their relatives showed there were sufficient numbers of staff on duty to keep people safe and meet their needs. Staff were seen to be busy but appeared to have time to meet people's individual needs. In addition to the nurses and care workers there were ancillary staff working in the units. These included, two activity workers, housekeeping, catering and laundry staff who also interacted with people while undertaking their roles. During our visits call bells were answered in a timely way. However there was no system to undertake formal audits of the call bells to ensure this was always the case. One relative said, "The home has improved over the last month, new furniture, decorations.

Staff have seemed to be more cheerful, not so rushed off their feet." Another said, "There always seems to be enough staff, they are always jolly." Staff said at times additional staff would be beneficial. Comments included, "There are enough staff but not all the time. When we have really poorly residents and have to do 15 minute checks it is hard"; "It is alright if all the residents are well but it can be stretched if someone is poorly"; "We do feel we need more staff at lunchtime to help people with their meals" and "There are enough staff. Sometimes we have crazy days and don't know which (people) to do first but we manage and the nurses will also help." We discussed this with the management team. The registered manager said they could always contact the operations manager at any time if they felt there was a need to increase staff numbers. The operations manager said staff completed dependency assessments on people to ascertain people's support needs. They also said the registered managers worked alongside staff and would be able to identify if there was a need to increase staff levels. They gave an example where in February 2016 they had increased staff levels at lunchtime because of a higher occupancy at the home.

Some people did not have call bells which were easily accessible. One person said they waited until staff came in. Another said, "I can't get hold of them, I can't find the bell, so shout and they come quite quickly." We discussed this with the management team. On our second visit they had spoken with these people and were trialling the use of a call bell with one of them. One person had sensory difficulties and it had been decided with them that a bell would not be appropriate. They had decided they would continue to call out when they required help as staff had arrived quickly.

There had been an ongoing problem retaining nurses at the home. The operations manager said retaining registered nurses at the service was having an impact with having enough nurses to cover the nursing duties. Therefore the registered managers were undertaking nursing shifts. They said they had spent a considerable amount of time firstly recruiting nurses. Then the registered managers and senior staff had worked alongside them putting them through an induction process. They then decided they were going to move on and leave the service for numerous reasons. One nurse said, "They come and go quickly… so we have problems with having enough qualified staff. It is frustrating when you have done all of this induction with them."

The operations manager said they were having difficulties having enough nurses to have two nurses on duty at night. At the time of the inspection the schedule showed there was a nurse and two care workers on duty on both units at night. People or staff did not raise any concerns about the staff levels at night. The registered manager was undertaking night duties and said they felt the staff levels at night met people's needs. The operations manager had completed a feasibility study looking at the options of having one nurse on duty at night with experienced care workers. They said they felt this would lessen the impact this was having.

People were protected because risks for each person were identified and managed. For example, the majority of people chose to wear plastic disposable aprons to protect their clothes at meal times. Two people had cloth aprons. Staff said this was because they were at risk of breaking pieces off and placing them in their mouth. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's mobility, choking, nutrition, pressure damage and falls. People who were identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included specialist mattresses on their beds and cushions in their chairs. Staff completed regular hourly checks on people who remained in bed. They looked at people's skin to identify any concerns. They assisted them to reposition themselves, and ensure they were comfortable, had drinks and their continence needs were met. All new people on arrival to the home had a risk assessment undertaken of their skin integrity to ensure they had no broken areas or concerns.

Manual handling risk assessments were undertaken. These looked at people's communication abilities, balance, medicines they were taking and then identified the level of risk using a traffic light system. For example, red for high manual handling support needs and green for low needs.

The environment was safe and secure for people who used the service and staff. A full time designated maintenance person and part time gardener over saw the maintenance at the service. They undertook regular checks of the service, which included, checking water temperatures, window restrictors, emergency lighting and wheelchairs. External contractors undertook regular servicing and testing of moving and handling equipment, gas, electrical and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout and had a homely atmosphere. There were flags and posters to commemorate the Queen's birthday on both units. One relative said, "The home has really improved new furniture, decorations and staff morale." Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Where there were occasional unpleasant odours in the home these soon cleared. One relative said, "No smells, always pleasant nice and clean."

Staff had access to hand washing facilities and used gloves and aprons appropriately. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal evacuation plans which took account of people's mobility and communication needs. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. Accidents and incidents were reported in accordance with the organisation's policies and procedures. They were reviewed by the registered managers to identify ways to reduce risks as much as possible and relevant health professionals and relatives were informed.

Requires Improvement

Is the service effective?

Our findings

The provider had not ensured all staff had undertaken mandatory training to ensure they had the required knowledge to meet people's needs. Improvements were seen at the last inspection with regards to staff training. The registered manager had put in place a system to ensure all staff received training. The system identified the staff who required training. Staff were then allocated training booklets to complete. However, there was no oversight to ensure all staff had completed the training given. We identified three staff that had not completed the provider's mandatory training.

Not all staff had received support with practice through supervision and appraisals. At the last inspection improvements had been seen with regards to staff having regular supervisions. However, this had not been maintained. The majority of staff on the Pinnexmoor unit had not received supervisions since our last inspection. The registered manager said they had delegated the task but had not ensured they had been completed.

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

The operations manager made us aware after the inspection, that they had taken action to address the gaps in staff training and supervisions. The three staff that had not completed the provider's mandatory training had been spoken with and were in the process of completing the required training workbooks. They confirmed all staff supervisions would be completed by the end of May 2016 and staff development plans put into place. Appraisals were also scheduled to be carried out for each staff member. They also confirmed a system to schedule on going future supervisions was being put into place to ensure all staff received supervisions.

Where staff had received training they said they had found the training beneficial and had helped them have the knowledge to meet people's needs. Comments included, "Really good, I felt the training was good here" and "We are given a booklet to complete which are very good… it would be nice to do more face to face training though."

Staff had undergone an induction which had given them the skills to carry out their roles and responsibilities effectively. They worked through an induction and orientation document in the first four to six weeks at the home. The document identified a list of tasks to be completed while shadowing on induction. These included understanding tissue viability, continence care, manual handling and the principles of fire safety. One new care worker had worked three to four days working alongside experienced staff and completed an induction file with their allocated mentor. They had also completed manual handling and safeguarding training. They went on to say they felt the training had been good and enabled them to deliver care. New staff, who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice.

New nurses as part of their induction also completed a competency assessment tool to ensure they had all

of the information needed to be in charge of a shift at the home. They had to demonstrate an understanding of what to do in the event of an emergency. For example, if they received a complaint, how to contact professionals and record keeping. Checks were made monthly to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses eligible to practise within the UK.

People who lacked mental capacity to take particular decisions were protected. The registered manager and staff demonstrated they understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and their codes of practice. The Care Quality Commission (CQC) monitors the operation of the DoLS and we found the home was meeting these requirements. Staff had completed MCA training and were able to tell how they used the knowledge in their role. Comments included, "We do make sure families can't consent unless they have health and welfare power of attorneys"; "Giving them (people) choices… their rights, understanding and keeping them safe" and "Giving them the choice of what they want."

The registered managers had made appropriate applications to the local authority to deprive people of their liberties. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered managers was aware of the Supreme Court judgement on 19 March 2014, which widened and clarified the definition of deprivation of liberty.

Where people lacked the mental capacity to make decisions the staff followed the principles of the MCA. Records demonstrated that relatives, staff and other health and social care professionals were consulted and involved in 'best interest' decisions made about people. For example, a best interest decision had been made for the safe use of bed rails. People's consent for day to day care and treatment was sought. Staff also gained consent from people at the service regarding sharing information, having a photograph taken and care plans. Where one person was unable to verbally consent to having their photograph taken for use on their health records, staff had recorded the person had smiled which implied their consent.

People were supported to have regular appointments with their dentist, optician, chiropodist and other specialists. Records confirmed the staff had worked with the speech and language team (SALT) and dieticians to address people's dietary health needs. One person also had involvement from the occupational therapist. Staff had supported them to undertake the recommended exercises.

When new people arrived at the home the staff completed a set of base line observations which included people's blood pressure and pulse. This was so the staff had a point of reference they could refer to if a person was taken unwell. Visitors said staff would inform them if their relative was taken ill. Comments included, "They will phone if there are any problems" and "They act quickly if (person) is unwell even if it just a bit of a cold."

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu. The cook said they were intending to start implementing the summer menu. They explained that people could have a variety of breakfasts which included crumpets, croissants, bacon, sausages and eggs. Extra snacks and supplements were also available as required. There were two main meal choices at the lunch time meal, with one dessert options. However, staff said people could have a yogurt or ice-cream if they did not want the dessert choice. On our second visit there was a choice of chicken and pasta bake or pork and apple pasties with mashed potatoes and a selection of three vegetables. There were other meal choices available on the request sheet. The sheet also identified the types of diet people required. Breakfast started at nine o'clock on both units. However staff said people could have breakfast earlier if they chose.

One care worker said, "Residents can have it when and where they like." We discussed the late start and concerns about the length of time between the previous evenings supper with the management team. They said people could have their breakfast earlier and each evening people were offered a late supper and could always have additional snacks.

We observed a lunchtime meal on both units, people were having meals as they had chosen and were positive about the food. Comments included, "It's lovely no problems at all"; "The food is plenty"; "Food is good. Every day they bring out a menu, you have a choice of two or three things. For breakfast I have rice krispies, because I like them. You can always have toast. We don't have cooked breakfasts here. We had a smashing dinner yesterday, we had bangers and mash…I only had two lots"; "It is ok, could be better" and "Food is very good."

At lunchtime on the Pinnexmoor unit we observed 16 people using the lounge, dining room or summer room to have their lunch. Other people were having their lunch in their rooms due to health needs or choice. People were given cups of juice. There were no menus to advise and remind people of the meal choice and tables were bare. On the Ashdowne unit some people chose to sit in their armchairs with small retractable tables to have their lunch and others in their bedrooms. However one person was not always happy they sat in their armchair. They commented, "We always eat on these tables, even Christmas dinner was served to us on here." Dining tables on both units did not have salt and pepper accessible for people to use. However on the Ashdowne unit when people requested them they were given.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented. One person had been identified as at risk from choking. They required a supplement to thicken the consistency of their drinks. Staff were guided in the persons care plan about the required syrup consistency. People at risk of weight loss had their weight monitored regularly. However, we noted one person's weight had discrepancies which was believed to be as a result of the weighing scales not being accurate which not been identified by staff. We discussed this with the unit lead and they said they would look into the concern.

The cook was knowledgeable about people's likes and dislikes and was aware of different food consistencies and requirements. For example, pureed, fork mashable, diabetic, soft options. The cook also informed us that the SALT were going to the unit to give the catering staff an update.

Good

Is the service caring?

Our findings

People were positive about staff and the care they received. Comments included, "The carers are ok"; "I like the staff but don't like new people coming in"; "I like it here, people (staff) are good."; "It's not bad, they are good, they look after me well. I tease them all about anything and everything"; "You can get on with the staff have a laugh with 90% of them" and "very nice really."
Another person said how the staff had banter with them which they enjoyed.

Visitors were complimentary about the care their relative received. Comments included, "Absolutely wonderful, home from home, homely, clean and wholesome. They are so patient with (person)"; "My wife gets care in the morning and at night… the staff are very good" and "In the main very good. I have to fetch somebody sometimes to make (person comfortable) but on the whole I am quite happy…pretty well looked after" A visiting therapeutic massager visited the home weekly to provider private services to people. They said, "Staff are lovely, very welcoming."

Staff felt the service was caring. Comments included, "We all try our hardest to do our best to keep people safe because we care."; "I do it mainly for the residents, they give me the motivation to carry on working" and "all of the staff are lovely we work well as a team and want to get it right for the residents."

During our visits staff interactions with people using the service were positive. Staff were patient whilst offering choices and involving people. Staff were kind, friendly and caring and people were seen positively interacting with staff. One person said "The staff are all very kind to me they get us up at 7.30." We asked the person what happened if they wanted to stay in bed. They responded, "You can always do anything you want…I get a bit cheeky."

Staff talked nicely to people, listened and answered them in a polite and caring manner. For example, a person asked to have their knee bandaged. The care worker stopped what they were doing and applied a bandage around the person's knee with lots of care and kindness. The person thanked them for how gentle they had been. Another care worker spent time with a person who was tearful and gave them a cuddle.

People were given support when making decisions about their day to day preferences and planning their own care. One staff member said, "It is up to them if they want to get up, have breakfast, drinks, where they want to go everything it is their choice." One person had made the decision not to be repositioned during the night. A risk assessment had been undertaken and their wishes carried out.

Staff treated people with dignity and respect when helping them with daily living tasks. Care workers supported a person using a hoist to transfer from a wheelchair into a more comfortable chair. They took time to explain to the person what they were doing and ensured they had understood. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. One care worker said, "We ask them to choose the clothes they want to wear, close the door and always explain everything." Another said, "We ensure their dignity…we don't shout across the lounge if someone is wet. We go over to the resident

and have a quiet word and take them to the bathroom."

People's rooms were personalised with different furniture, pictures, plants and lots of soft animals. There were ornaments on window sills and the doors were numbered with a laminated picture, for example trees in a garden setting with people's names. One person said, "I have a nice room with lots of photos which makes it more homely but wouldn't be here by choice."

People's relatives and friends were able to visit without being unnecessarily restricted. People's comments included, "My family are made to feel welcome" and "My family comes in regularly and chats with me." Relatives said they were made to feel welcome when they visited the home. One relative said, "Every time we come in we feel welcome." Another said, "I can come in anytime." One care worker said, "I like it that they (people) can bring in personal belongings and family can stay any time."

People were asked about where and how they would like to be cared for when they reached the end of their life. Staff identified which funeral directors people wanted to use, who they wanted to be informed and where they wanted to spend their last days. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. People were receiving end of life care at the home at the time of our visit. The staff worked closely with people's families and health professionals to ensure they were informed. They had worked with people's GP's to ensure medicines had been prescribed to be used to help people at the end of their life and remain comfortable. Specific end of life care plans had been put into place to guide staff how to keep the people comfortable. This included regular mouth care, repositioning and continence care. Staff demonstrated compassion and kindness to the people receiving this care and to their visiting family. One relative said they were very pleased with the care and support their relative, they and their family had received. They said, "All of my children have sung the homes praises. I was able to stay overnight to be able to sit with (person). They have been so comforting; they put an arm on your shoulder. I can't praise them enough".

Good

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was well planned and delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. This information was used to develop comprehensive care plans. Care plans were in place to meet people's needs and focused on the person and their individual needs, choices and preferences and contained personal histories. These care plans included, pressure ulcer prevention, communication, personal hygiene, diet elimination, disturbed sleep pattern, organic brain syndrome, aggressive behavioural and suffering paranoid ideas. Care plans were detailed and gave staff guidance how to meet people's needs. For example, a person had been assessed as being at a high risk of falling. The care plan made staff aware the person was unable to identify they had poor mobility and were at risk of falling. They were also instructed to ensure the person had their walking frame nearby to use. Another care plan for a person who had disturbed sleep, advised the staff that the person may shout out. It explained this may be due to hallucinations or disorientation and might be triggered by memories of a traumatic experience as a child. Staff were guided to spend time with the person reassuring them and helping them to become more orientated to where they were.

The nurses undertook monthly or 'as required' basis assessments of people's on going needs. These were reflected in people's care plans as required. For example, when a person had lost weight, staff had recorded the actions they had taken and the monitoring of the person's weight had been increased. Where another person was unable to express their need to use the toilet, their care plan advised staff what signs to look for and how the person presented. A staff member said, "We work with new residents to make sure things are in place, choice of room, input into care. We work with the new person to do what they want."

The registered manager had tried to involve people and their relatives in reviews of their care plans. This had been successful in some cases and had not been achieved in others. They confirmed they would continue to try and encourage people and their relatives to be actively involved. People and relatives said they were happy with the care they received. Comments included, "Its lovely no problems at all, to me anyway"; "I am pleased with this home, staff are good and we often discuss my mother's care, we don't have official meetings but whenever I ask the staff are pleased to talk about it" and "We saw the care plans six months ago." One person could not recall seeing their care plan and said, "I just take it as it comes."

Staff said they had read some people's care plans but gained most of their knowledge through handovers and communication with colleagues. One care worker said, "It is an organised home… we get a clear handover where each resident is discussed and everyone is friendly." It was evident when we asked staff about the care they provided to specific people that they knew their needs well. They were able to say what they needed to do for these people which was consistently the same as what was recorded in their care plans. For example, where a person was receiving end of life care, staff could tell us the care and support they required. A second example was their understanding of a person who had some behaviour which could be challenging to the service. Staff knew how to reassure the person appropriately, techniques of distraction and when it was appropriate to leave them to settle.

We observed a staff handover in the dining room in the Pinnexmoor unit. Staff coming on duty were made aware of people's dietary and fluid intakes and changing health needs. However, this was in the vicinity of people using the service. We discussed this with the management team and they said they would look at alternatives to maintain people's privacy.

People were happy they could raise a concern if they needed to and were confident the registered managers would listen and take action if required. One person said, "I would be quite happy to tell someone if I wasn't happy." Another said, "I would speak to the nurse she would do something about it." One person said while cuddling one of their numerous teddy bears, "I really like it here, everyone is nice to me, I can't complain." A visitor said, "I wanted (person) to come here, it is a good home, I have no complaints, the staff do their best." Another visitor said, "If I had a concern I would go to (long standing registered manager) and she would deal with it."

The provider had a complaints procedure which included information about the external agencies people could contact if they were not satisfied with the response from the service. However, one person did not have an up to date service user guide in their room to inform them of relevant outside agencies they could contact. The guide referred to the predecessor to the Care Quality Commission (CQC) and the 2001 regulations. It also identified that the Commission would investigate complaints which is not part of CQC's role as a regulator.

There had been no new complaints since our last inspection. The registered manager had a good understanding of the provider complaints procedure, which they had followed for previous concerns.

There had been numerous thank you cards and letters sent to the registered manager thanking them and the staff for the care people had received at the home. Some comments from letters received in 2016 included, "From the time he came to Pinnexmoor, he was shown such immense kindness and care'; 'Many many thanks for the care and treatment for my wife…thanks also for the welcome afforded to me and the caring love and affection that I have received on my regular visits" and "Your staff team have been magnificent always welcoming and willing to tell us how mum is getting on. Despite the visits being unannounced mum always looked very well cared for and as comfortable as they could make her. The whole team have been wonderful; they work hard and have hearts of gold." Another relative wrote, "On each and every occasion I visited, I was impressed by the individual tailored care given to him by all of the staff. His room was always spotless and Dad was always well looked after at whatever time of day or night I visited. Staff knew him well and he responded to them in a manner that gave me great confidence that he was happy. He was treated with great respect…staff knocking at the door as they came in showed this. … they worked with him with great patience and compassion, never looking rushed."

People were supported to follow their interests and take part in social activities. The provider employed two people to support activities, one for each unit. Records demonstrated that every person in the home had at least a weekly session of meaningful activities. This was either by joining in group activities or where people chose not to leave their rooms the activity person would undertake a one to one visit. There were also external entertainers and craft providers who visited the home to entertain people.

Records demonstrated that the registered manager had met with the activity person to discuss plans for the Easter and queens birthday celebrations at the home. In the Pinnexmoor dining room and along the corridor people's art work was displayed. This included a flower mural and art to reflect the queen's birthday. One of the activity staff involved people in preparing some banners for the Queen's birthday. As part of the discussion they mentioned to one person, "You can have a face mask if you want, I can bring my make up tomorrow and you can have a makeover." The person appeared thrilled by this suggestion. People

also enjoyed seeing a dog brought in by a visiting relative. People's special occasions were also celebrated at the home. For example, cakes to celebrate people's birthdays.

A staff member said, "Activities here have come on leaps and bounds. (The activity person) thinks outside of the box of what residents can do and their ability."

Good

Is the service well-led?

Our findings

The location had two registered managers; the second registered manager had joined the service in February 2016. The contractual agreement with the provider was that both registered managers undertook 12 hours a week nursing duties. However, due to the difficulty retaining registered nurses at the service both registered managers had been undertaking additional nursing duties during the day and at night. Both registered managers confirmed having two managers was working really well. One explained that there had been concerns raised about practices during the nights at the home. They had undertaken night duties on both units to monitor and support. They went on to say there was a lot of enthusiasm with the care staff and it was important they felt they could report internally and that the management team was receptive. The new registered manager had prioritised getting to know people, relatives and staff. They had undertaken a dementia training to increase their knowledge further of working with people living with dementia.

The provider had sent letters to local health and social professionals regarding the change in management structure. Staff on the whole were reasonably positive regarding the new registered manager. One staff member gave an example of where they had made the new registered manager aware of an issue with a pad being put into the laundry by mistake. The registered manager had taken action straight away and spoken with staff to try and stop it happening again. The staff member said, "She gets things done." Another gave an example of when the registered manager took the time to work with them regarding changing a person's dressing. They had assessed their competency to undertake the task unsupervised in the future. Other comments from staff included, "(Registered manager) is approachable and understanding and a good listener. I needed time off … it was not a problem. The registered manager came into a room the other day and said we did not need to use too much cream (topical). They explained why it was not needed, always very professional." A third staff member said, "(The registered manager) is clued up on mental health, not task orientated, not regimented."

The registered managers were supported by a unit lead on the Ashdowne unit with a vacancy for a unit lead on the Pinnex unit. They were supported by registered nurses and care workers. Staff said they felt supported by the nurses and registered managers. There were not designated senior care workers at the home although staff said more experienced care staff took the lead to run the shifts. Staff had a clear understanding of their roles and responsibilities. The operations manager also undertook regular visits to the service to support the registered managers and undertook quality monitoring checks. This included speaking with people, visitors and staff to ask them about their experiences and views. They also audited a random sample of people's care records, staff files and service management records. They made us aware after the inspection that they had made changes to their quality monitoring visits which included a new audit form introduced in April 2016. This included the over sight of training, which had not previously been identified as an issue. They also undertook an observational visit and watched the care of selected people, looked at their records, checked employment records and staff training of two staff involved in their care. Staff were positive about the operation managers visits. One staff member said, "I can go to (operations manager) if I need anything."

The provider had a number of quality monitoring systems in use which were used to continually review and

improve the service. The registered managers had a schedule of required audits and reviews to be carried out each month. These included, catering reviews, medicine audits, falls analysis, activity reviews, infection control, visual premises checks and diabetic audits.

The provider encouraged open communication with people who use the service, those that matter to them and staff. People using the service and their relatives were encouraged to complete an annual satisfaction questionnaire. The operations manager said the questionnaire were imminently scheduled for 2016. Comments cards had also been used at the home and been collated monthly with action plans formulated. People and visitors were asked about the atmosphere at the service, about the way staff carried out their work. One example where they had been asked about was how staff had involved people and visitors regarding the care provided. The seven responses were positive with three saying excellent, two good and two acceptable. Where a person had made comments on food and drink, action had been taken. This consisted of a meeting with the catering staff to advise them of the comments made and the registered nurses had been advised to monitor.

Meetings had been held for people and relatives to be informed about changes and give their views. The next meeting was scheduled for May 2016. In December 2015 the registered manager had also undertaken a walk around to speak with relatives on the Pinnexmoor unit to ask their views and discuss concerns

Staff were asked their views on the service. Staff had completed a staff quality assurance survey in the spring 2015 and the collated results demonstrated the staff were happy working at the service and their suggestions were listened to. The registered managers had held meetings with staff. These included meetings with individual teams, for example the catering team, unit leads, registered nurses and the maintenance team. The records of the meeting held with the maintenance person and gardener in March 2016 discussed improvements to the garden in the Pinnexmoor unit and the new storage area being developed in the Ashdowne unit. At a registered nurse meeting in November 2015 they were given feedback regarding a pharmacy visit. This included new charts to be used regarding anticoagulating medicines and as required medicines and the use of medicine patches.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared. Staff were also kept up to date about people's requirements by information recorded on a handover sheet and a white board. This kept them updated about people regarding their resuscitation wishes and identified who did not use a call bell. This meant staff were kept up to date about people's changing needs and risks.

There were accident and incident reporting systems in place at the service. The registered manager reviewed all of the incident forms regarding people falling. They looked to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they took action to find ways so further falls could be avoided. The registered managers completed a monthly analysis sheet for the provider. This included information regarding staff recruitment and leaving, incidents and falls analysis and occupancy.

In September 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored five with the highest rating being five. This confirmed good standards and record keeping in relation to food hygiene had been maintained.

The provider had displayed the previous Care Quality Commission (CQC) rating of the service in the entrance of both units. However, they had not displayed the rating on the provider's website. We discussed this with the operations manager and this was addressed by the end of the inspection. This meant the registered

managers and provider were meeting their legal obligations. They had also notified the CQC as required, providing additional information promptly when requested and working in line with their registration.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that people were supported by staff who had the appropriate training and supervision necessary to enable them to carry out the duties they are employed to perform, 18(2)(a)