GrayAreas Limited

Kingsmount Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 19th and 20th April 2016.

Kingsmount Residential Home is a care home for older people some of whom may be physically frail or living with dementia. At the time of our inspection there were 22 people living at Kingsmount. The home has two lounges, one of which is a smaller "quiet" lounge with direct access to a small garden area containing garden furniture at the rear of the property. The dining room leads off from the main lounge. All bedrooms are pleasantly decorated, some with fantastic sea views and all are fitted with a call system and have access to bathroom and toileting facilities.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered manager had been in post for seven years and was highly regarded by the staff, residents and their visitors. The management team had a positive and proactive approach to managing the home and maintaining high standards of care.

People who live at the home told us they felt safe, and we found that the provider had a number of systems and processes in place to promote safety. Staff received training in and understood their responsibilities in safeguarding of vulnerable adults. We found risks to individuals were well assessed and staff applied measures to minimise risk to people. However, risk assessments did not clearly document what measures the home had put in place to minimise risk to individuals. This was discussed with the registered manager and immediate action was taken to address this.

Care plans contained assessments of people's capacity to make decisions in line with the Mental Capacity Act 2005. Where people lacked capacity to make a decision we saw documentation of best interests decisions and who had been involved in making those decisions.

People received personalised care and staff treated them as individuals and with respect. Staff knew peoples' likes and dislikes. We saw staff offering people choices and people who lived in the home, where able, told us how they made choices in relation to their care and support such as when they wanted to get up, what they wanted to eat and where they wanted to spend their day.

There were systems in place for monitoring the quality of the service and the care and support that people received. If there were areas for improvement that were highlighted through the audit process there were action plans to rectify the issues.

Recruitment processes were robust and thorough checks were always completed to make sure staff were

safe and suitable to work in the care sector before they started work at the home. Staff had received sufficient training to support them to carry out their roles. They received regular supervision and appraisal. They told us they felt supported by the management team and were comfortable making suggestions.

People were supported to take their medicines. Medicines were secured safely and accurate records were maintained. Safe systems were in place to manage medicines so people received their medicines at the right times.

People were given a choice of nutritious and seasonal home cooked meals. There were plenty of hot and cold drinks and snacks available between meals. However, we had mixed reviews from people about the quality of the food provided. Some people told us they liked the meals and they had plenty to eat. Some people remarked that the food was inconsistent and not very hot. We saw good support given to people who needed assistance to eat. We saw that staff were patient with the people they were supporting and did not rush them.

People had their healthcare needs identified and were able to see healthcare professionals such as their GP or dentist when they needed to. Staff knew how to access specialist professional help when needed.

The home employed an activity coordinator and offered a variety of different activities for people to be involved in. Whilst we were there we observed a number of activities in the communal rooms, including group sessions and people having individual activities more suited to their needs and preferences such as playing chess and having their nails painted. However, we found that people who chose to stay in their rooms did not receive meaningful activity and were often only stimulated by the television or radio playing. We were also told by people and their relatives that there were no outside activities offered.

We have made a recommendation that the home seek advice and guidance from a reputable source, about supporting people at risk of social isolation.

The home was clean, tidy and free from odour and effective cleaning schedules were in place. It was decorated to a high standard and people's rooms were personalised. There was an on going decorating improvement plan in place to ensure constructive adaptations are made to meet individual needs and accessibility, for example grab rails in bathrooms. Although the home supported people living with dementia, communal areas and corridors were not well signed and the floor coverings in the lounge and communal areas were highly patterned which was not suited to the needs of people living with dementia.

We have made a recommendation that the provider should take advice from a reputable source to ensure that the home's environment is suitable for people living with dementia.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were appropriately actioned.

We found the provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support.

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 told us they felt safe. Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Care plans recorded risks that had been identified in relation to people's care and support and these were appropriately managed.

There were enough staff employed to ensure people received the care they needed and in a safe way.

There were effective recruitment procedures and practices in place and being followed.

Medicines were safely stored and administered to people.

Is the service effective?

Good

The service was effective

Staff had the knowledge and skills to meet people's needs, and these were updated through attendance at training courses. Staff received supervision from their managers to ensure they had the support to meet people's needs.

People's rights were protected and respected because staff understood the principles of the Mental Capacity Act 2005.

People were given a good choice of food and drink and were provided with regular snacks and refreshments throughout the day.

People were supported to maintain their health and had access to healthcare services when they needed them. Referrals were made to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection. People spoke positively about the staff and said they were kind and caring.

People were treated with dignity and respect and staff were knowledgeable about people's support needs.

Staff encouraged people to make choices about their daily life style. Staff knew people well and what their preferred routines were.

Is the service responsive?

Requires Improvement

The service was not always responsive

People had care plans in place to reflect their current needs. Care was centred on the person. Care plans were reviewed and people were involved as much as possible with the planning of their care to ensure they received personal care relevant to their needs.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

We saw people were encouraged and supported to take part in a range of activities on a day to day basis. Although there were minimal activities offered to people who spent time in their rooms.

Is the service well-led?

Good

The service was well-led.

There was a visible, open and approachable management presence and people spoke highly of the management team. Staff were well motivated and supported to work in a transparent and supportive culture.

The service had effective systems in place to monitor and improve the quality of the service.

There were sufficient opportunities for people who lived in the home and their relatives to express their views about the care and the quality of the service provided.

Kingsmount Residential 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 unannounced inspection took place on the 19th and 20th April 2016 and was conducted by an adult social care inspector.

As part of the inspection we reviewed the information we held about the service. We looked at previous inspection reports and other information we held about the home including notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make. We also spoke with one health professionals for their opinion of the home.

During the inspection we looked around the home and observed the way staff interacted with people. We spoke with nine people who used the service, five relatives and one visiting health care professional. We also spoke with the registered manager, deputy manager, four carers, the cleaner, the cook and the maintenance man. We observed how staff interacted with the people who used the service throughout the inspection.

We also spent time looking at records including four care records, four staff files, medication administration record (MAR) sheets, staff training plans, complaints, policies and procedures, audits, quality assurance reports and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said "I really feel safe here" another said "Yes I feel safe here, there is always someone around to help". Due to people's complex health needs most were unable to tell us verbally about their views of the care and support they received. We observed people were smiling and giving eye contact to those around them, including staff. This indicated they were comfortable and relaxed. We saw that staff knew people well and recognised signs of anxiety or upset through changes in behaviours and body language. Relatives we spoke with told us they thought their loved ones were safe. One relative said, "It's a big relief knowing she's in safe hands".

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Staff told us if they had any concerns they would report them to the registered manager or deputy manager and were confident they would be followed up appropriately. We saw the registered provider had policies and procedures for safeguarding adults from abuse which included information on speaking out at work (whistle blowing), reporting and recording abuse. The home displayed details of the local authority safeguarding teams and the action to take when abuse was suspected. This information was freely available to staff.

The registered manager had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs, including an assessment of risk for falls, nutritional status, moving and handling and pressure care. These were reviewed monthly and amended accordingly. We saw that some risk assessments did not explain how the home was managing the risk. For example one person's risk assessment identified that they were at risk of falling at night. The risk assessment documentation did not identify how this was to be managed. We saw that the risk to the person had been recognised in practice as the person had an alarm mat next to their bed at night to alert carers of their movements. However, this safety measure was not reflected in their risk assessment to provide adequate guidance for staff. Another person's risk assessment identified them as being at risk of skin or pressure damage. We saw that staff were taking appropriate actions to manage this risk. For example, using a pressure relieving mattress and frequently assisting the person to change their position in bed. But again this was not recorded on the risk assessment. Staff told us that they knew peoples needs well and had regular handovers and updates where new information was passed onto them.

Although in general, risk assessments lacked detailed recordings about how a risk should be managed, we observed that staff were using good risk reduction strategies in their day to day care of people. For example staff ensured that people had pressure relieving cushions in their chairs, people cared for in their beds had pressure relieving mattresses and were assisted to regularly change their position to avoid tissue damage caused by immobility. Staff we spoke with also understood the importance of monitoring the condition of people's skin, keeping accurate records and notifying the registered manager of any changes to people's skin. We discussed the risk assessment documentation with the registered manager who immediately amended the risk assessments of all people living at the home to reflect how their individual risks were being managed.

People told us that there were, on the whole, enough staff on duty to support them at the times they wanted or needed. One person told us that there was always someone around to help them. However, another person said "They can take a while to answer the bell, they're so busy". We asked permission from the person who felt they had waited longer than they would have liked, to share their feelings with the manager so that they could follow this up. The registered manager told us that they were aware of this persons feelings an had investigated their complaint fully and had taken measures to rectify the issues with the person and their GP. The registered manager explained that recently due to the closure of a residential home in their group, Kingsmount had increased their workforce and as a result they anticipate that delays in answering people's call bells would reduce. This would be monitored in the future.

We spoke with people's families and they told us, "There are enough staff around to look after my mum and the other people", another relative said " I think it's pretty well staffed, staff ratio to people is good". We observed that on the day of our inspection, there was sufficient staff on duty and that people received assistance and support when they needed it. We observed that people's needs were met in a timely manner and with staff working to the pace of people. For example staff assisted people at meal times at a pace that suited the person and did not rush them.

The registered manager worked out how many staff were needed based on people's needs and made sure that there was at least this number of staff on duty. If more staff were required to support people's changing or increasing needs, or if new people moved in the home, the registered manager and deputy manager would respond by working alongside staff and working in partnership with their sister care home to ensure that the needs of the people were being met. On the day of our inspection as well as the registered manager and deputy manager, there were six carers in the morning and five in the afternoon. The carers were supported by a chef, kitchen assistant, administration staff, maintenance staff, laundry and cleaning staff so that the care staff could concentrate on caring for people. The registered manager told us that there was always a manager on duty over the weekends and a senior carer on call overnight.

Recruitment processes were robust. We looked at recruitment and selection procedures and reviewed four staff recruitment files. We saw staff had completed an application form and a range of checks were undertaken which included taking up two references and identity checks. A Disclosure and Barring Service (DBS) check was undertaken prior to staff starting work. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. These measures ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. The home had a disciplinary policy in place to deal with staff misconduct. We saw that where staff's conduct came in to question, processes were in place to investigate and deal with the issues. However, there appeared to be a lack of documented follow up on the actions agreed from the investigations. This was discussed with the registered manager who confirmed that staff had in fact received support and supervision following disciplinary intervention but this had not been formally recorded. An action plan was put in place for this to happen immediately.

People's medicines were administered safely. Medicines were managed, stored, given to people as prescribed and disposed of safely. We looked at the Medicines Administrations Records (MARs) for people and found that administered medicine had been signed for. Each person had their photograph on the MAR chart. This was to help ensure each person received the medicine that was prescribed for them by their GP. We noted where medicines had been prescribed on a PRN (as needed) basis staff followed the provider's protocol. The medicine record for each individual prescribed PRN medicines contained information about each medicine prescribed, the reason for administration, possible side effects and the signs and symptoms a person may display to indicate they required the medicine. For people living with dementia who may have

difficulty expressing their pain needs, staff were able to describe how they use the "Abbey Pain Scale" to assess their analgesic needs. The Abbey Pain Scale is best used as part of an overall pain management plan and is designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

Staff monitored and recorded storage and fridge temperatures daily. Staff were trained in managing medicines and confirmed they understood the importance of safe administration and management of medicines. We were told by the registered manager that the management team conduct random twice weekly medicine audits to check medicines were being managed and administered in line with their policy. They also monitored staff administration compliance by carrying out random spot checks throughout the year.

People told us the home was always clean and tidy and odour free. There were systems in place to monitor and audit the cleanliness of the home. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice throughout the inspection. The registered manager told us that they took infection control practices very seriously to ensure the safety of the people. Staff's hand washing technique was checked randomly each month by using a UV light box. UV light boxes are used to demonstrate the flaws in the hand washing technique and is a recognised aid in infection control and management. However, during our tour of the building it was noted that there were toiletries left in the communal bathrooms which could potentially be an infection control risk and a potential swallowing risk for people with dementia. We discussed this with the registered manager who took immediate action to remove the items and inform staff that people's toiletries should be kept in their rooms.

Accidents and incidents at the home were recorded by staff for the registered manager to monitor and manage. The deputy manager told us they used the information to look for trends in the accident records to learn and improve from any incidents that occurred. Any trends were thoroughly investigated and appropriate referrals to other professionals such as the falls team, district nurses and general practitioners were made as well as reviewing risk assessments and changing people's care plans.

Checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and portable appliances. We saw that the water temperature of showers, baths and hand wash basins in communal areas were taken and recorded on a regular basis to make sure that they were within safe limits. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

The provider had carried out a fire risk assessment and staff were aware of the procedures to be followed in the event of a fire. The fire alarm system and fire fighting equipment were checked and serviced regularly. We saw Personal Emergency Evacuation Plans (PEEP) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

Good

Is the service effective?

Our findings

People were cared for by staff who had the skills and knowledge they needed to provide effective support. People told us that staff knew them well and provided their care in the way they preferred. One person said, "They're very good and aware of what I need" and another person told us, "The staff all know my likes and dislikes." Relatives told us they were confident in the skills and abilities of the staff who cared for their family members. One relative said, "My mum is looked after very well".

Staff we spoke with told us they found the registered manager and deputy manager very supportive and could approach them at any time for support or guidance. Regular supervision and appraisal sessions took place offering staff an opportunity to raise any concerns they may have, or discuss progress and development setting goals and identifying training needs.

Staff had the knowledge and skills to enable them to support people effectively. All staff had completed an induction programme. As part of the induction training staff also underwent a period of shadowing with an experienced staff member to assist them to learn about their role. New employees undertook the new Care Certificate Standards course (CCS); the recognised qualification set for the induction of new social care workers.

We looked at staff training records which showed staff had completed training in a range of areas such as manual handling, first aid, food hygiene, safeguarding adults, fire awareness, medication, infection control, deprivation of liberty safeguards (DoLS) and mental capacity. The training record showed staff had completed their required training and sessions were booked to ensure staff practice remained up to date. In addition to statutory training requirements, staff were offered training to improve on and build their skill base and individual interest areas in care. Staff attended recent courses tailored to the needs of the people such as dementia care and end of life training that was provided by the local hospice and have been invited back to attend disability awareness training in the future. One staff member told us how the training helped her do her job better and another felt that the staff were all very well trained.

People's rights were protected in line with the Mental Capacity Act 2005.The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA and as least restrictive as possible. We saw examples of best interest decisions being taken on behalf of people, where it had been assessed they did not have the capacity to make specific decisions. Documentation contained details of who was consulted and involved in the decision making process. The assessments clearly identified the day to day decisions the person could make independently and the support required for more important decisions that may need to be made. Staff confirmed they had received training on the principles of the MCA and understood what it meant to make a decision in a person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of their responsibilities under the DoLS and had completed assessments and submitted application forms to request for DoLS to the relevant Supervisory Body.

People were asked for their consent before care was provided. Throughout the two days we observed staff seeking consent both prior to and when delivering their care. People were given time to consider options and staff understood the ways in which people indicated their consent. One carer, talking about a person she was key worker for, described how she knew from their facial expression whether they wanted to do something or not. They told us that if the person indicated that they did not want to do something they would come back and try again later and would always respect the person's wishes. Relatives confirmed that staff always sought permission before and during care and support.

People we spoke with had varying views about the food provided. One person told us, "We can choose what we want, the roast beef is nice" another said "[name] has a very good appetite, he's liked most things". We were also told by people that the food was inconsistent. One person commented "The food hasn't been the same since January, sometimes it's not very hot" and "Sometimes its very good, sometimes not, a bit hit and miss". We spoke with the registered manager about the negative views of some people and were told that, due to unforeseen circumstances, since the beginning of the year the kitchen staff had changed. We were assured that the chef was always working towards improving the food and menu offered. The registered manager said that they would pass the comments on. Everyone we spoke with confirmed that they all got enough to eat and were always given a choice. We saw and people told us that drinks were provided on a regular basis throughout the day.

We observed the lunch time meal and saw that people's dietary needs and preferences were met. Staff were attentive to people's needs and checked throughout the meal that people were satisfied and enjoying their meal. Staff demonstrated good practice when supporting people. They ensured that people were positioned correctly and provided support at an appropriate pace. They encouraged people to eat and engaged with them positively, making conversation in addition to focusing on the task at hand.

The chef had detailed dietary information displayed for each person who used the service. This included information about allergies and food intolerances and any individual recommendations made by the speech and language therapists such as people who required soft diets and drinks fortified with extra calories. People's preferences were displayed including their preferred choice of drinks and how they take them. Menus were rotated on a four weekly basis and was changed according to what is most popular with people. People's individual preferences were known by the chef as they were recorded on the daily menu record and people were offered a choice of foods that they liked if they did not want what was on the menu.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This identified the frequency with which people should be weighed in order to monitor their wellbeing. Information was also used to update risk assessments and make referrals to relevant health care professionals. Nutrition screening assessments were included in care plans documenting specific dietary instructions. For example the screening assessment identified that one person was having difficulty chewing food and would require them to have their food cut up into small pieces. We saw staff put this into practice during the person's lunchtime meal.

People's healthcare needs were met. We saw that people were supported to see healthcare professionals, for example their GP, optician, dentists and community nurse.

The home was well decorated and had an on going improvement programme. The home had a highly patterned floor covering in the lounge and corridors which was not suited to the needs of people living with dementia. For example, we observed one person trying to pick up the flowers in the carpet pattern in one of the lounges. People living with dementia may mistake patterns as litter or flowers and may attempt to pick up what they are seeing. This may result in the person falling. Although the home supported people living with dementia, communal areas and corridors were not well signed. We discussed this with the registered manager at the time of our inspection and they told us that these improvements have been acknowledged by the provider and would feature as part of their refurbishment programme.

We recommend that the provider should take advice from a reputable source regarding the signage, decoration and floor covering to ensure it is suitable for people living with dementia.

Good

Is the service caring?

Our findings

People spoke positively of the staff and said they were caring and respectful. One person told us, "Everybody here is very, very kind, if we want something they get it for us, what more can we want?" another said "The staff are nice, they are very helpful". Relatives commented, "Staff are just brilliant, they're fabulous I can't speak highly enough of them" and "What they're doing is making sure that they are comfortable, warm, well fed and looked after". We saw that people engaged positively with staff and staff communicated with people in a friendly manner.

We heard staff chatting with people in the lounge and as they walked around the home, offering people support and reassuringly holding people's hands where necessary. People's needs were responded to quickly if a person became distressed or upset. For example one person was becoming distressed and we saw that a member of staff immediately went to them and offered them reassurance in a kind, caring and supportive way, placing a comforting arm around them. The person responded positively to this.

Staff were attentive to people's needs. We saw that staff communicated well with people living at the home. For example, staff were seen to kneel down beside the person to talk to them or to sit next to them. Staff provided clear explanations to people about the care and support to be provided. We observed staff assisting people from wheelchairs to lounge chairs by explaining the whole procedure to them and that they wanted to make them more comfortable.

Staff told us an important part of their role was to encourage independence. One member of staff described how they encouraged people to wash and dress themselves as much as they are able to maintain their independence. Staff told us how they supported people to make choices. For example, asking them what they wanted to wear. They went on to describe how they tried to make it easier for people to choose their clothing for themselves by laying out their tops in one area and trousers in another so that the person would choose one of each.

People were well presented and their personal care needs had been attended to. People's hair looked clean and washed and they were dressed in clean and co-ordinated clothes and jewellery, appropriate for the time of year.

Staff were heard routinely asking people for their consent throughout the inspection and had a good understanding of people's non-verbal communication needs that ensured their rights were respected. One staff member described how they always start each task with the question "would you like…..?" they went on to describe how they understood from people's facial expressions and vocalisation if they were happy to proceed with their routines and said that they would always give the people a choice.

People were treated with sensitivity, respect and dignity. We observed people were spoken with respectfully using their preferred name and staff showed an understanding of the importance of confidentiality. Staff told us that they would always respect peoples privacy and dignity and described how they would knock on doors before entering and close curtains and doors when providing personal care.

People's friends and relatives visited when they chose and the home encouraged people to maintain relationships that were important to them. Relatives we spoke to said they felt welcomed at all times. One relative said "I come here at all different times. I am very happy with it here." Another relative said that they visit the home every day and was very impressed with the care.

People's preferences for end of life care were discussed and recorded. We saw that where people lack the mental capacity to discuss their wishes; this was discussed with family members and GP. The home encourage family involvement and support families at this difficult time, with open visiting and carers made available to sit with people to provide emotional support as necessary.

The provider had received positive written feedback from a number of people and their relatives. Comments included; "You are an exceptional bunch and you all help to create a lovely homely atmosphere for all that live at Kingsmount" and "Thank's for making [name] stay so comfortable and safe" and "Thank you for your kind care of [name], he was looked after so professionally and although only with you for 6 months, it felt like his home".

Requires Improvement

Is the service responsive?

Our findings

People told us staff provided their care in the way they preferred and relatives said staff responded to their family members' needs. One person said "The staff all know my likes and dislikes". Another person said they found staff were very helpful and would offer support where needed.

Pre-admission assessments were undertaken prior to people moving into Kingsmount so that the home understood their care needs and preferences. Important information was gathered about previous life history, as well as important relationships. Following an initial assessment, care plans were developed detailing the care needs and support required to ensure personalised care. Care plans were person centred, and provided clear guidance to staff about how people's care and support needs should be met, their preferred routines and life history. Care plans started with the dementia society tool "This is me" to help staff get to know the person. "This is me" is a tool for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes. Staff confirmed that they knew peoples needs by reading the care plans. They said "It's good to know the people you are looking after" and "It's about getting to know them all, understanding the resident's needs".

The care plans were updated regularly with the input of people where ever possible, to ensure that the information was accurate and a true reflection of the person's current needs. Relatives told us they had been involved in care planning and providing some information about their family member including things such as their life history. They told us they had also been involved in reviews of their family members care. One relative said "They seem to know her quite well, they understand what she needs. They try to involve her in her paperwork".

Staff were responsive to people's changing needs. One relative told us their family member had recently had problems with ill-fitting false teeth making it difficult to eat. The home responded immediately by arranging for the person to be seen by a dentist and altering the persons dietary requirements to softer foods whilst they waited for their new teeth to be made. Staff told us they monitored people's health and any changes were discussed during handovers to ensure people received appropriate support.

People were supported by their individual key worker. The registered manager explained that every person was allocated a key worker who would look after their needs, know them well and speak up as their advocate. A key worker is a designated member of staff that undertakes additional tasks for a person. This could be ensuring the person has sufficient toiletries as needed and that information in their care plans are kept up to date. All of this information supported staff to provide individualised care to people.

There was a wide range of activities available for people to access at the home. These included social events held at the service such as quiz afternoons, bingo, music sessions, DVD film afternoon and various participation games such as giant hoopla, ball games, giant snakes and ladders and skittles. A list of planned activities were posted around the home to let people know in advance what was happening. People told us "There are usually lots of things going on if you want to get involved ". One person said how they enjoyed reading the books provided in the library area. During our visit we observed people and carers

playing chess, looking through picture books and reminiscing and we saw people having their nails painted. We were told about how the staff try to engage people by using their past experiences to stimulate them. For example, one person had worked in an office when they were younger and liked to come into the registered manager's office and file paper into different piles. Another person had been a housewife and enjoyed going down to the laundry room to fold washing. Staff told us about how they try to make sure that people are engaged in activities they like. For example one staff member told us how they had downloaded some old photographs to their mobile phone. They described how they used these to distract and facilitate reminiscence conversation with a person they had accompanied on a recent visit for to audiology appointment. They found that this helped the person relax so that they did not become as distressed as previous visits.

The registered manager told us that they had recently developed the role of personalisation pioneer who was responsible for assessing people's interests and hobbies and developing person centred activities tailored to each individuals needs and preferences. All interactions were recorded daily and their needs re-assessed monthly.

We spoke with some people who were unable to go to lounge and found that they had very little interaction to stimulate them. One person told us that the carers were too busy to talk with them and they were often left to watch television. We looked at the activity plans for the people who spent time in their rooms and found that they were consistently being left with just the television or radio for stimulation. There was no documented evidence of meaningful one to one interaction and therefore this exposed people to social isolation. Relatives also told us that they were unaware of any one to one activities for people who spent time in their rooms. People and their relatives also commented on the lack of outside activities or trips. One relative said "[name] needs more stimulation and outside activities, she hasn't been outside since she got here". We brought these observations to the attention of the registered manager who said that they would liaise with the personalisation pioneer to improve social activities for people at risk of social isolation.

We recommend the home seek advice and guidance from a reputable source, about supporting people at risk of social isolation with engagement in meaningful activity and stimulation.

The service had a complaints policy in place with clear details of how people could complain if they were not happy about the service they were receiving. A copy of the complaints policy was available and displayed at the main entrance and in the service users guide book, which was available in every persons room. We spoke with people and their relatives and asked them if they knew how to complain, they told us that they did know how to complain and had every confidence in the management team that any concerns or complaints would be dealt with satisfactorily. The registered manager told us that they had not had any formal complaints since 2014 as they like to take a pro-active approach and open communication with people to immediately resolve issues as they arise. The registered manager described the process for dealing with complaints that include an investigation resulting in a summary of actions, outcomes and a written response to the complainant within defined timescales.

Good

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager was on duty and supported us during the inspection, along with a deputy manager. There was positive feedback from everyone we spoke with about the leadership and there was a high degree of confidence in how the service was run. Staff we spoke with told us the home was well led and the management team was visible on a daily basis and supported them well creating an open culture in the home. Staff confirmed they felt confident to report any concerns to them. Comments included "They're brilliant, go to them with anything", "There really is an open door policy. I think they are amazing" and "[name's] very supportive, if you need anything [name's] there, you can go to [name] if something is wrong". During the inspection we saw the registered manager and deputy manager were accessible to staff and spent a great deal of their working day out of the office checking staff practice and ensuring people's needs were met.

Relatives told us they were happy with the way the service operated and said that the home had, "Very approachable management, communication is really good, I have no problems with them", and "They are always very co-operative and willing to speak. I find I can always go and discuss things". One relative commented that they felt that the home was very well organised and managed. This was echoed by a visiting general practitioner who was very happy with the care their patients' received. They commented that they found the home knew their residents well and were always able and willing to respond to requests and instructions to make sure people's needs were being met. They felt that the management team was well organised and led by example.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities. The registered provider told us on the PIR, "The single influence ensuring a quality service is it's leadership; the home has to be inspired by it's directors and senior managers who in turn support and listen to its leaders managing a home". To ensure the home was providing a quality responsive service, the provider undertook unannounced monitoring visits to identify any matters in need of attention. A range of quality assurance audits were completed by the registered manager to help ensure quality standards were maintained and legislation complied with. The data was presented and reviewed at company management level monthly. These included audits of risks such as weight changes, hydration and nutrition risks, pressure ulcers, medication errors, falls and number of residents on calming medication. There were no significant actions identified from any of the audits we looked at.

All staff were made aware of their role and responsibility within the organisation and received regular feedback on their work performance through the supervision and appraisal systems.

The registered manager communicated with staff about the home and staff were encouraged to give their feedback. This included regular staff meetings and we saw minutes of meetings that had taken place. General issues were discussed and the registered manager provided them with up to date information on aspects of the service and good practice. The registered manager told us that these meetings were an opportunity to discuss the care given and how to improve care and that staff were encouraged to make suggestions to improve care. This showed that the service had an open culture and the views of staff were

valued.

Surveys were undertaken with people who lived in the home, their relatives and visiting health care professionals to ascertain their views about how the home was run. The surveys identified various topics for people to comment on such as perception of the general ambience of the home, perception of the cleanliness and décor of the home, people's involvement in care planning and view of the running of the home. These views were collated and analysed with action plans set to address any short falls. We were told by the registered manager that they had invited people and their relatives to residents meetings but found that due to the large amount of people living with dementia, meetings were not well supported. The management team always ensured that people knew they could approach them at any time.

Accidents and incidents were monitored on a monthly basis as a means of identifying any particular trends, patterns or lessons to be learnt in the types of incidents occurring. The registered manager was aware of the responsibilities associated with their role. The registered manager was aware of when notifications had to be sent to CQC and had submitted these as required. These notifications would tell us about any events that had happened in the home. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

People's needs were accurately reflected in detailed plans of care and risk assessments were in place where necessary. People's records were of good quality and fully completed. Records relating to other aspects of the running of the home such as health and safety maintenance records were accurate and up-to-date. The provider had put in place a large number of policies to underpin service quality and safety. These include procedures related to environmental safety, staffing and care practices. The policies and procedures were comprehensive and had been updated and reviewed as necessary.

The registered manager ensured that they kept themselves and the home up to date with best practice by attending "matrons forums" run by the NHS Care Trust, Intermediate Care Contract Providers meetings and was responsive to local health service needs by working in partnership with Torbay Care Trust. We found the registered manager and deputy manager were personally committed to the service, and demonstrated compassion, and knowledge in their roles.