European Care (England) Limited

Pavillion Care Centre

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Pavillion Care Centre provides nursing and residential care for up to 68 people. The home provides care and support for people, some of whom were living with dementia. At the time of this inspection there were 68 people living at Pavillion Care Centre.

This was an unannounced inspection. The home had a registered manager. A registered manager is a person

Summary of findings

who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We last inspected Pavillion Care Centre in June 2013. At that inspection we found the service was meeting all the essential standards that we inspected.

We found the provider had breached Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not have accurate records to support and evidence the safe administration of medicines. We found gaps in medication administration records (MARs) for 28 out of 30 people who used the service where medication had not been signed for to confirm it had been given. We also found that a daily check on the accuracy of MARs had also not been completed consistently. You can see what action we told the provider to take at the back of the full version of the report.

Some Mental Capacity Assessments had not been completed in line with the requirements of the Mental Capacity Act 2005 (MCA) as some records we viewed were incomplete and inaccurate. However, staff we spoke with had a good understanding of the MCA. We found that for some people where there were doubts about their capacity, advance decisions about their future care wishes had been made. We found that these were kept in a separate file rather than within people's individual care records. The provider acted in accordance with the requirements of the Deprivation of Liberty Safeguards (DoLS). Where required DoLS applications had been made to the local authority.

During the two specific observations we carried out we saw that people received inconsistent care. Although during these times most people received positive interactions from staff there were some people who had a less positive experience and others who did not have their support needs met in a timely manner. We also observed the care people received at other times during the day and found staff to be kind and considerate towards people. For example, staff explained to people what they were doing and provided reassurance.

People we spoke with told us they felt safe living at the service. Family members also confirmed this. One family member commented, "I get a call from the home if anything is wrong and as soon as I enter the home staff give me an update on care."

People said they received good care from staff who treated them kindly and with dignity and respect. They said, "I find the staff lovely and caring, I am well fed and looked after, I have choice and I have no complaints at all", "I love it here, everyone is so nice and kind, and I am really well looked after", "I am happy and content here and I am well looked after", "I have a lovely room, the staff are polite, I can join in activities if I wish and I have no complaints about my care", and, "I am treated very nicely, the staff are pleasant and caring." Family members also told us that they were happy with the care their relative received. During our inspection we only received positive comments from people and family members.

Staff we spoke with had a good understanding of the needs of the people they were caring for. They also had a good understanding of how to keep people safe and knew how to respond to safeguarding concerns and behaviours that challenge. Staff told us they were well supported to carry their caring role and could approach the manager with any concerns they had.

The provider had systems in place to identify people who were at risk of poor nutrition. We saw that accurate records were kept so that staff could monitor people's dietary intake. We observed throughout the day that staff were supported to meet their nutritional needs. One person said, "The food was always lovely and I really enjoy meal times."

People were supported to access healthcare when required. The provider made referrals to relevant professionals to ensure staff had access to specialist advice and guidance to help them care for people.

People were supported to make choices and have their preferences met. They were empowered to become or remain as independent as possible and continue to access the local community. People had the opportunity to access a wide range of activities both inside and outside of the home. There was effective communication between the home and family members.

The home had been adapted to meet the needs of people living with dementia. For example, using bright

Summary of findings

colours for the internal décor to help with people's orientation, clear signage, promoting personal memorabilia to encourage reminiscence and using dementia-friendly beakers and crockery.

The home had an effective complaints procedure. None of the people or family members we spoke with had made a complaint about the care they received.

People had the opportunity to give their views about the service. For example, there was regular consultation with people and their views were used to improve the service.

The provider undertook a range of checks and audits as part of its quality assurance programme to assess the quality of care provided. This included both internal and external checks on the quality of care delivered. The findings from audits were used to make improvements to the service and this information fed into an over-arching action plan for the service. Records showed that staff regularly logged any incidents and accidents, which included the specific details of the incident or accident and the action taken to deal with the situation. Information was analysed to look for trends and patterns and to identify learning to improve the quality of the care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe. Medicines were not handled appropriately as medication records were inaccurate and did not evidence the safe administration of medication. Some Mental Capacity Act assessments had not been completed appropriately. People's advance decisions about their future care needs were not immediately accessible within their care records.

People told us they felt safe living at the service. Family members also confirmed that they felt their relative was safe.

There were enough staff on duty to meet people's needs. Staff had a good understanding of safeguarding and how to report any concerns they had. They also had a good understanding of how to respond to people when they displayed behaviours that challenge the service.

Is the service effective?

Good

The service was effective. People were supported to meet their nutritional needs. The provider had systems in place to identify people who were at risk of poor nutrition. We saw that accurate records were kept so that staff could monitor people's dietary intake. We observed that staff provided the support that people needed, such as one to one assistance with eating and drinking. We found that staff had the training and support they needed to fulfil their caring role.

People were supported to access healthcare when required. Health professionals visited the home regularly and people were supported to attend health appointments.

The provider made referrals to relevant professionals to ensure staff had access to specialist advice and guidance to help them care for people.

Is the service caring?

Requires Improvement

Most aspects of the service were caring. We observed the care that people received throughout our inspection and found inconsistencies. Although most people received good care from staff some people had a less positive experience.

People and family members were happy with the care they received. People and family members we spoke with gave us only positive comments.

We observed throughout our inspection that people were treated with dignity and respect. Staff had a good understanding of the importance of maintaining people's privacy and dignity and gave us practical examples of how delivered care to ensure they achieved this aim.

Summary of findings

Is the service responsive?

Good 

The service was responsive. Staff supported people to make choices and to remain as independent as possible. People told us they were able to make their own choices and were asked for permission before receiving care. Family members told us there was good communication with the home.

People could access a range of activities both inside and outside of the home. Staff had a good understanding of people's needs including their likes and dislikes and any special needs they had.

The home had an effective complaints procedure. None of the people or family members we spoke had made a complaint about the care they received.

Is the service well-led?

Requires Improvement 

The service was well-led. Staff told us the registered manager was supportive and could be approached at any time for advice.

People had the opportunity to give their views about the service and these were used to improve the service.

The home had a quality assurance programme to check on the quality of care provided. However we found that medication audits had not been completed consistently. Information from a range of sources including incidents, accidents and complaints was analysed and used to improve the quality of the service. We identified many examples of changes that had been made as a result of the home's quality assurance programme.

Pavillion Care Centre

Detailed findings

Background to this inspection

We inspected Pavillion Care Centre on 16 July 2014 and 8 October 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection was carried out by two inspectors, an expert by experience and a specialist adviser both with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. We also contacted the local authority commissioners for the service, the local healthwatch, the clinical commissioning group (CCG) and the GP and district nurse who worked with the service.

We spoke with 14 people who used the service and 19 family members. We also spoke with the registered manager and nine members of care staff. We observed how staff interacted with people and looked at a range of care records which included care records for eight of the 68 people who used the service, medication records and recruitment records for five staff.

During this inspection we carried out observations using 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 communicate with us.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

Medicines were not handled appropriately. During our initial visit to Pavillion Care Centre we looked at the medication administration records (MARs) for all people who used the service. We found the dates on the MAR for one person were unclear as staff were using a temporary MAR as they had just moved into the home. This meant that it was difficult to check if medicines had been given at the correct time each day. We discussed our findings with the nurse on duty who corrected the MAR immediately.

On 8 October 2014 we visited the home again. This was because we had received information that nurses were signing people's MARs to indicate that medication had been administered when in fact the person had not received their medication. We checked the medication records for the previous four week period and found that the amount of medication administered and the amount of medication disposed did not match. We were unable to tell with certainty from viewing these records whether people had not received their medication on time. This was because any unused medication had already been disposed of as part of the standard monthly process operated in the home. We also viewed the MARs for 30 people who used the service and found gaps in signatures for 28 people where medication had not been signed for to confirm it had been given. This meant that the provider did have accurate records to support and evidence the safe administration of medicines.

People were not adequately protected from the risks associated with the unsafe use and handling of medicines. This was because the system introduced to check that MARs were completed accurately was ineffective in ensuring gaps in the records were identified. We found the provider completed a 'Daily 10 point MARs check.' We spoke with an external manager about this check and asked what its purpose was. They said, "[It was] supposed to be a secondary check to ensure there are no gaps in the MAR chart and checked by a peer.' They also said it was "supposed to be done after every medication round." Therefore there should be four checks on MARs carried out each day. We checked the completed 'Daily 10 point MARs check' records for the period 8 September 2014 to 5 October 2014. We found that these records were incomplete and ineffective as they had not been carried out consistently. For example, a full check which included all four medication rounds had only been completed on 11 dates out of 28. We also found that on four dates no checks had been done at all.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff maintained other records relating to medication such as medicines received and disposed of, fridge and treatment room temperature checks and records relating to drugs liable to misuse (known as controlled drugs). These were up to date at the time of our inspection.

Some Mental Capacity Assessments had not been completed in line with the requirements of the Mental Capacity Act 2005 (MCA). MCA is a law that protects and supports people who do not have the ability to make decisions for themselves and to ensure that decisions are made in their 'best interests.' Some MCA records we viewed were incomplete and inaccurate. For example, one assessment we looked at was not dated. Another assessment was incomplete as it indicated that the person lacked capacity but there was no further information on the form. Therefore it was not clear what the decision being taken was or the outcome of the assessment. Although some assessments were not completed correctly, staff understood the principles of the MCA. They described when MCA assessments would be applicable and how decisions would be assessed and made when people lacked capacity.

For some people where there were doubts about their capacity, advance decisions about their future care had been made. For example, 13 people had 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions in place. We saw that these had been made jointly between the person's GP and their family. We found that these were kept in a separate file rather than within people's individual care records. This meant that there was a risk that should the person become ill, health professionals treating the person may not be aware of their DNACPR decision.

The provider acted in accordance with the requirements of the Deprivation of Liberty Safeguards (DoLS). These are safeguards to ensure care does not place unlawful restrictions on people in care homes and hospitals. The registered manager had a good understanding of DoLS. We

Inadequate

Is the service safe?

saw that recent DoLS applications had been made to the local authority for two people who used the service. The registered manager also reviewed deprivation of liberty monthly as part of the home's programme of quality assurance checks. The provider had a specific policy and procedure in relation to DoLS which had recently been reviewed.

People we spoke with told us they felt very safe in the home. Family members told us the care their relative received helped them to feel reassured. One family member commented, "I get a call from the home if anything is wrong and as soon as I enter the home staff give me an update on care."

Staff we spoke with showed a good understanding of how to identify and respond to safeguarding concerns. Staff told us, and records confirmed, that they had completed safeguarding training. Staff could tell us about different types of abuse and gave examples of potential warning signs. For example, a person becoming very withdrawn, marks, bruising and changes in a person's usual behaviour. Staff said that if they had any concerns they would report them immediately to the registered manager. We viewed the safeguarding log during our visit and found that safeguarding concerns had been logged correctly. These had been dealt with using the appropriate procedures and reported to the local authority. The provider had also made the required notification to the Care Quality Commission. People told us that they were aware of safeguarding issues and said they would know what to do if there was a problem. People and their family members said if there were any incidents they would go straight to the manager.

Staff had a good understanding of how to manage people's behaviours that challenge the service. They were able to describe the specific strategies they used, which were individual for each person. For example, staff told us one person responded positively to having a cup of tea and a chat. Another person liked to have a look at personal photographs for re-assurance. Staff said they would refer to each person's 'challenging behaviour' support plan for guidance about which strategies were appropriate for each person. At one point we observed that staff intervened with one person who was becoming agitated. They held the person's hand and asked if they would like to help with getting the juice ready. We saw that the person responded to the staff member's interaction positively and they became more relaxed.

Where staff had identified a potential risk, either during the initial assessment or after admission, we found that a risk assessment had been completed to ensure people were safe. We found from viewing care records that people were routinely assessed against a range of potential risks, such as falls, nutrition, moving around, continence and keeping safe. We saw that these had been completed for each person and corresponding care plans had been developed to help staff manage any risks identified.

We observed that staff were visible throughout the home and that people were never left unsupervised. Staff told us there were enough staff to meet people's needs. They said that they usually had enough time to spend one to one time with people and have a chat. We saw that the registered manager regularly reviewed staffing levels to ensure there were enough staff to meet people's needs. The registered manager used a specific tool, which considered people's dependency levels when calculating minimum staffing levels.

There were systems in place to ensure that new staff were suitable to care for and support vulnerable adults. New staff had been recruited in line with the provider's recruitment process to ensure they had the required skills, qualifications and knowledge to support people. We viewed the recruitment records for five staff. We found the provider had requested and received references in respect of prospective new staff, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments. Where required, following the DBS check, additional checks and a risk assessment had been undertaken to confirm that new staff members were suitable to work with vulnerable adults.

Good

Is the service effective?

Our findings

People were protected against the risk of poor nutrition. Staff assessed people for the risk of poor nutrition using a recognised assessment tool (Malnutrition Universal Screening Tool). We saw that five out of six assessments we looked at had been reviewed monthly and that the reviews were up to date. For one person who had lost weight we found the assessment had not been reviewed since February 2014. However, we saw that the person had been identified as having swallowing difficulties and had been referred to a speech and language therapist. The person had subsequently been assessed and advice and guidance given to staff. We found that one person's records contained contradictory information. The dietary assessment and associated dietary support plan identified the person as 'diabetic.' However, their eating and drinking support plan stated, '(The person) has no dietary requirements.' We saw from other documentation that she was known to be diabetic and appropriately supported.

We spoke with staff about how they knew whether people had eaten enough. They said after lunch staff wrote up people's care notes and recorded what each person had eaten and drunk. They said people living with dementia were weighed weekly to ensure they were not losing weight. After lunch we checked people's food and fluid charts and found they had been completed appropriately. The records had been completed with what people had eaten for breakfast and lunch and any drinks they had been given. This meant staff had access to accurate and up to date information about people's dietary intake.

People told us they were happy with the food served at meal-times. One person said, "The food was always lovely and I really enjoy meal times." One family member told us, "(My relative) does not eat well but the staff keep the family aware of what is happening and if (my relative) keeps asking for cornflakes then we have agreed (my relative) should be given them as well as protein supplements. We have a chart in the room which tells us what (my relative) has eaten."

We observed over a lunch-time to see whether people had a pleasant dining experience. We saw that the tables were set ready for people when they came into the dining room. People were offered a choice of a juice drink before their meal and a hot drink afterwards. We saw that people were offered a choice of meal. We observed that two people required one to one assistance from staff with eating and drinking, which they received uninterrupted. We saw that another person was experiencing difficulty eating their food. Staff respected the person's right to refuse assistance but still continued to offer their support. We also saw that throughout the day people were regularly offered a choice of drinks and snacks, such as cake or biscuits. This meant people had the support they needed to ensure their nutrition and hydration needs were met.

Staff told us they were well supported to carry out their caring role. They said they had regular supervision with their manager, usually every three months and an appraisal. Staff said that the provider was pro-active and supportive of staff undertaking training. One staff member told us they were up to date with all of their training and they had lots of it. They said all staff were expected to complete dementia training. Staff had the opportunity to do more specialist training. One staff member told us that they had been supported to access training in relation to venepuncture, tracheostomy care and diabetes. Other staff members had completed specific training in relation to meaningful activities, leading a team and counselling. Staff said, "The manager is very approachable", "I am well supported, I can go to any senior and the other girls are easy to talk to", "If you ask for specific training you get it", and, "(The registered manager) makes sure training is up to date."

People had regular input from health professionals. We saw examples within people's care records of involvement from various health professionals, such as the GP, district nurses, specialist nurses, and speech and language therapists. A local GP and district nurse visited the home weekly and were present on the day of our inspection. Relatives told us staff contacted them if there were any health or care issues they needed to know about. We observed staff assisting one person who had swallowing difficulties with eating and drinking. Staff were attentive and ensured the person's food was finely chopped. We saw from viewing the person's care plan that staff had acted in accordance with the speech and language therapist's guidance. This meant people were supported to access relevant professionals to help them meet their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

We carried out a specific observation in one of the communal lounges using SOFI. We saw that throughout the 30 minutes of our observations people received very little interaction from staff. The communal area was divided into a dining area in one half and a lounge area in the other half. The layout of the seating in the lounge area meant that when staff were in the dining area they could not observe some people. Therefore we saw that staff missed some cues that people required support. For example, two people became physically and verbally aggressive towards each other. Staff could also not see or hear that another person asked repeatedly for something to eat and drink. We discussed our observations with the senior care worker on duty. They immediately reported the incident between the two people, assessed each person and started regular observations. The senior told us that they would normally have the "girls" sitting and chatting with people but that one person was about to leave unexpectedly for hospital so the "girls are run ragged."

We undertook a second observation for 30 minutes over the lunchtime using SOFI. We saw that throughout our observations people received regular interaction. Most of the interactions we observed were positive. For example, staff gently woke one person with advanced dementia and sat with the person to encourage them to stay awake to eat their food. The staff member was gentle and considerate and allowed the person the time they needed to eat their food. Staff assisted another person who was struggling to eat their meal. They supported the person to move closer to the table so they could reach better. They also changed the person's knife for a spoon to eat with which they found easier to use. People responded positively to this interaction and their mood state improved. However, for three people the interaction from staff was not positive. For example, on two occasions staff took away a person's plate without speaking to or acknowledging the person.

At other times throughout our inspection we observed staff interacting with people and found them to be warm, caring and appropriate. Staff assisted people to move around the home with care. They explained to people what they were doing and provided reassurance. We saw that when staff interacted with people they were focused on the task and communicated directly with the person they were supporting. We observed throughout the day that staff sat with people and chatted with them. One staff member told us they liked the fact that they got to spend one to one time with residents as it gave them the chance to really get to know the residents and give them quality time.

People were happy with the care they received. People we spoke with gave us only positive comments. People commented, "I find the staff lovely and caring, I am well fed and looked after, I have choice and I have no complaints at all", "I love it here, everyone is so nice and kind, and I am really well looked after", "I am happy and content here and I am well looked after", "I have a lovely room, the staff are polite, I can join in activities if I wish and I have no complaints about my care", and, "I am treated very nicely, the staff are pleasant and caring."

Staff told us they adapted their approach when communicating with people to support them with making decisions and to help with their understanding. For example, they said for some people they would speak slowly, provide clear instructions, repeat information and give good eye contact. For other people staff said they would use 'flash' cards or picture cards. Staff we spoke with were very aware of the needs of people. For example, they were able to tell us about people's individual needs, such as special dietary needs and family issues. One staff member told us about recent training that they had completed about communicating with people who were unable to speak. They said they found this helpful so that "you can get to know people's preferences and offer them choices even if they were non-verbal."

People were treated with dignity and respect. Staff had a good understanding of the importance of maintaining people's privacy and dignity. One staff member said, "Everybody has to have dignity and respect." They gave us practical examples of how they delivered care to achieve this aim. For example, staff said if a person spilled anything on them they would discreetly accompany the person to their own room to support them in private. They said that when delivering personal care they would make sure the person's door was closed. Staff said that they would always explain to a person what they were doing. During our inspection we observed staff treating people with dignity and respect. For example, knocking on doors before entering people's rooms and speaking with them in a calm and pleasant way.

We spoke with staff about the care they delivered to people and we particularly asked then to tell us what the service

Requires Improvement

Is the service caring?

did best. They commented: "(The) staff have a genuine warmth for residents"; "(The) staff are person-centre aimed, each and every one"; "This is a good home, everybody treats everybody the same"; "Good staff team, friendly and good rapport with residents and family"; and, "Really good activities, people have lots to do and go out regularly."

Good

Is the service responsive?

Our findings

Staff responded to people's individual choices and preferences. We observed that throughout the day people were asked to make choices, such as whether they wanted to be involved in activities or to stay in their own room, what to eat for breakfast and what they would like to drink. For example, we saw that one person had their lunch in a lounge during mid-afternoon. They told us that was what they wanted. The person said, "I just have to ask, there is never a problem." People were empowered to be independent and have control over their own living space. For example, people were assessed to see whether they would be able to manage their own key rather than rely on staff. We found people were supported to follow their interests. For instance, one person had been provided with display cabinets in their room as they were interested in collecting ornaments.

There was effective communication between the home and family members. Family members told us that the manager contacted them as soon as possible if there was an issue, such as a health problem. We observed during our inspection that when family members visited the home staff updated them about how their relative was.

People were supported to develop links with the local community. For example, we found that a local hairdresser visited Pavillion Care Centre one day a week. People told us that on another day the hairdresser closes her shop and they had the opportunity to go to the shop to have their hair done. One person said, "I am taken over to the shop and I have a cup of tea, it is lovely." Staff told us that a group of people from the dementia unit were supported each week to attend a singing group at a local school. People also took part in trips out with staff or family members, such as to parks and garden centres.

People had the opportunity to take part in a wide range of activities. Staff gave us examples of activities people could take part in, such as watching TV, listening to music or taking part in group activities organised by the two activity co-ordinators. For example, we observed that some people living with dementia were involved in a 'tasting session' activity. We saw that marshmallows, grapes, banana and melted chocolate were put on a plate for each resident to experience the different textures and flavours. We observed that all of the people took part and enjoyed the session.

People had their needs assessed both before and after they were admitted to home. We found that the assessments were used to develop individual care plans. We saw from viewing care records that staff had gathered information about people's life stories. Staff we spoke with said they were up to date with people's life stories. They said these had been developed with input from people and family members. Staff told us that they found these to be a "good tool." This meant staff had access to detailed information to help them better understand people's needs.

Care plans we viewed were individualised and took account of people's choices, likes and dislikes. For example, the cook spent time with people when they were admitted to record their food preferences. All of the care plans we viewed had been reviewed monthly and the reviews were up to date at the time of our inspection. We saw that care plan reviews evidenced that staff responded to changes in people's needs. For example, one person was found to have restricted shoulder mobility. We saw that staff had assessed the person and ensured they had access to medical assistance. The person had been admitted to hospital. Records showed that staff had continually assessed and monitored the situation until the person had been examined, diagnosed and treated.

People were asked for their permission before receiving care. We saw some evidence of formal consent within people's care records, such as for bedrails, photography and information sharing. However, people had not signed any of the care plans we viewed to show they had consented to them. Staff told us they would always ask people first before delivering any care. They said if a person refused they would talk to them about it or try again later but would always respect their right to refuse. Staff said if they had on-going concerns about a person refusing care they would speak with their senior or a nurse for advice. One staff member said, "People have the right to say no."

The registered manager had adapted the home to meet the needs of people living with dementia. For example, using bright colours for the internal décor to help with people's orientation, clear signage, promoting personal memorabilia to encourage reminiscence and using dementia-friendly beakers and crockery. We observed as we walked around the home that people had their own personal possessions, memorabilia and reminiscence materials in their rooms. We saw that thought had been given to the use of space within the home and the

Good

Is the service responsive?

environment supported people with dementia. For instance, there were no designated areas within the home for people with dementia. People were able to explore the home as they wished and take rest breaks in one of the many seating areas throughout the home.

There was an effective system to handle complaints. We found the provider had a complaints procedure that people could access if they had any complaints. We viewed the home's complaints log during our visit. We found there had been three complaints recorded. Records showed that the complaints had been investigated and action taken to respond to the concerns raised. None of the people or family members we spoke with raised any concerns about the care they received at Pavillion Care Centre. None of the people we spoke with had made any formal complaint. However, one family member said they had raised some small issues which had been addressed straight away. They said, **"**The family are happy with the care here and the staff. I have only raised a couple of small issues with staff and they have been put right straight away."

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post. They were a member of the Tyne and Wear Care Alliance steering group. Part of the steering group's role included identifying training needs and organise training to be delivered in the local area. The registered manager gave us examples of previous training that had been made available through the Tyne and Wear Care Alliance, such as dietetics, swallowing difficulties and oral hygiene. The staff we spoke with told us that the manager was approachable and had a regular presence around the home. Staff said the registered manager had been with the service "for years", "listens to staff" and "knows a huge amount about dementia." Staff told us that the registered manager was supportive. They said the registered manager was "always around", "really approachable", "runs the home very well", and, "we get a lot of support from (the registered manager)."

The provider did not have effective systems in operation to assess and monitor the quality of medication records to ensure gaps were identified, investigated and appropriate action was taken in a timely manner. During our inspection we found gaps in signatures in on 28 out of 30 MARs that we checked. We also found that a further daily check on whether people's MARs had been completed appropriately had also not been done consistently. We asked an external manager what other checks were in place to audit the quality of medication records. They said, "A weekly audit and a monthly audit. They [staff] have not been doing the weekly audits." We viewed the last monthly medication audit and found that this had not been completed in August 2014 and September 2014.

The provider had a vision and a set of values that underpinned the care that staff delivered. The registered manager told us that the provider had recently re-launched its vision and values following a re-branding and a change of name. The registered manager also told us that the supervision and appraisal system had recently been changed so that it was aligned to the provider's vision and values. We saw that a pocket guide to the vision and values had been developed and made available to staff. Although staff told us they were aware the provider had a vision and values, staff we spoke with were unable to tell us what they were.

Staff we spoke with knew about the provider's whistle blowing policy. They told us they had not needed to use it so far but felt confident they would be treated fairly and their concerns would be taken seriously.

People had the opportunity to give their views about the service. We viewed the most recent 'customer satisfaction' survey which had been done in January 2014. The registered manager told us that 68 surveys had been issued and they had received 26 replies. We saw that the registered manager had analysed people's feedback and improvements had been made as a result. For example, new signage had been purchased and additional training provided for staff. The manager told us that due to the low response the survey was being repeated. This was on-going at the time of our inspection. The registered manager held a regular 'evening session' once a week for people to give their views and an email address was available for people who wanted to communicate electronically.

The provider undertook a range of checks and audits as part of its quality assurance programme to assess the quality of care provided. The registered manager completed a monthly 'quality checklist' which included audits of the kitchen, dining room, laundry and people's care records including care plans and risk assessments. The findings from the audits were used to develop a monthly action plan which identified areas for improvement. For example, the most recent action plan we viewed identified that some care plans needed updating. We found that some issues identified through the home's audit systems had not been addressed. For example, one person's 'consent for photograph and information sharing' form had not been signed. We saw that a note had been made in the person' records stating 'needs signing.' However, the note was dated 02/04/2014 and was still not signed at the time of our inspection.

A senior manager external to the service also undertook a regular audit. We viewed the most recent audit which had been carried out in July 2014. We saw that the audit included gathering the views of people who used the service, staff and relatives. The records showed that people were happy with the service. The audit also included a check on safeguarding concerns, complaints, health and safety and the environment.

There were systems to log any incidents and accidents and any 'untoward events' that happened at the service. This included incidences of skin damage and any sudden

Requires Improvement

Is the service well-led?

deaths. Records showed that staff regularly logged any incidents and accidents, which included the specific details of the incident or accident and the action taken to deal with the situation. For example, ensuring people received medical attention, starting regular observations to keep people safe and reviewing risk assessments.

Information was analysed to look for trends and patterns and to identify learning to improve the quality of the care provided. The registered manager undertook a weekly falls analysis which was used to identify any further action to keep people safe, such as a referral to the 'falls' team, increased monitoring or medical assistance. Each incident and accident was reviewed and any lessons learned or actions required to prevent recurrence were recorded, such as developing or updating care plans to ensure they reflected the person's current needs. The registered manager carried out an annual review of all complaints received. We viewed the most recent review and saw that lessons learned had been recorded. For example, to ensure key workers were known to new people. The service had an overarching operational action plan which identified specific timed actions to improve the service. These were reviewed and monitored using a colour coding system to indicate progress towards completing the action. Examples of actions identified in the action plan included reviewing and publishing people's feedback from the consultation, ensuring staff had completed mandatory training and reviewing staff vacancies and taking action to address any gaps.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have accurate records to support and evidence the safe administration of medicines.**