Tamaris Healthcare (England) Limited

Regents View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 October 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Regents View Care Home in October 2015, at which time the service was compliant with all regulatory standards and was rated Good. At this inspection the service remained Good.

Regents View is a care home in Hetton-le-Hole, Sunderland, providing nursing, accommodation and personal care for up to 50 older people. There were 40 people using the service at the time of our inspection, the majority of whom were living with dementia. This included a male-only area of the home, where there were currently eight people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected by staff who understood specific risk assessments and care plans. Risks were reviewed and acted on with the input of external professionals where appropriate.

People and their relatives told us there were ample staff. The registered manager and some staff acknowledged the workload could be particularly challenging when there were unexpected staff absences and they were recruiting more staff in an attempt to reduce this likelihood and impact.

Staff demonstrated a good awareness of safeguarding principles and had received refresher training on the subject, as well as recent moving and handling refresher training.

The management, administration, storage and disposal of medicines was in line with the National Institute for Health and Care Excellence [NICE] guidelines.

The laundry used a 'dirty in clean out' two door system and was in good order. We found the home to be clean and well maintained.

Pre-employment checks were made to reduce the likelihood of employing people who were unsuitable to work with potentially vulnerable people.

Breakaway training, in order to equip staff with the skills to safely remove themselves from a physical altercation, had yet to be delivered. All other mandatory training was in place and monitored regularly. This included health and safety, fire safety, infection control, mental capacity, food hygiene and dementia awareness.

Kitchen staff demonstrated a strong awareness of people's dietary requirements and preferences. Mealtime experiences were varied and sometimes people had to wait for their meals.

The registered manager was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were some dementia-friendly aspects to the environment, for instance wide, bright corridors with contrasting walls, tactile murals on walls. Other areas, particularly the male-only area, required refurbishing with people's needs in mind.

Staff received consistent support through supervision and appraisal meetings, as well as staff meetings.

People who used the service, relatives and external professionals agreed staff were caring in their approach to people and we observed evidence of this during our inspection. People were treated with dignity and respect.

Care plans contained sufficient person-centred information and staff had a good knowledge of people's needs, likes and dislikes.

The service had a full time activities co-ordinator. Weekly activities and outings were planned although more could be done to ensure people in the male-only area of the home had access to a range of activities meaningful to them.

People's changing healthcare needs were reviewed and external advice and support was sought and acted on regularly.

There were a range of checks and quality assurance processes in place to review the systems in place and outcomes for people. The registered manager took a lead on this auditing work and was supported by the area manager. They made appropriate notifications to CQC and liaised with external stakeholders to source training and other opportunities.

Relatives we spoke with, staff and external professionals were positive about the approachability and effectiveness of the registered manager. We found the culture to be a hard-working one, which focussed on people feeling secure and well cared for.

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 who used the service felt safe, whilst relatives and external professionals raised no concerns about people's safety.

Previous safeguarding incidents had been appropriately reported and lessons learned. Additional training had been provided where necessary.

People's medicines were stored, administered and disposed of safely; regular competency checks and audits ensured errors were minimised.

Infection control was well managed and the home was found to be clean throughout.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had yet to implement training regarding breakaway training. All other mandatory training was in place and monitored regularly.

People's dietary requirements and preferences were met by a kitchen team who displayed a detailed knowledge of people's needs. Mealtime experiences we observed varied and staff deployment meant people sometimes had to wait for their meals.

There were some dementia-friendly aspects to the environment, although other areas, particularly the male-only area, required refurbishing with people's needs in mind.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well-led.

Regents View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 10 and 11 October 2017 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. The inspection team consisted of one Adult Social Care Inspector, one specialist advisor and one expert by experience. A specialist advisor is someone who has professional experience of this type of care service. An expert by experience is a person who has relevant experience of this type of care service. The expert and specialist advisor in this case had experience in caring for older people and people living with dementia.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with professionals in local authority commissioning and safeguarding teams, as well as Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We asked the provider to complete a Provider Information Return (PIR). This is a document where the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

We spoke with four people who used the service and five relatives. We spoke with eleven members of staff: the area manager, the registered manager, one nurse, one care home assistant practitioner (CHAP), five care staff, the cook and the kitchen assistant.

During the inspection visit we looked at four people's care plans, medicines records, risk assessments, staff training and recruitment records, a selection of the home's policies and procedures, meeting minutes and

maintenance records. We saw the service's IT-based feedback, quality assurance and incident/accident reporting systems.

We spent time observing people in the living rooms and dining areas of the home, for instance during people's mealtimes. We inspected the communal areas, kitchen, bathrooms, toilets and laundry. After the inspection we spoke with two external health and social care professionals.

Good

Is the service safe?

Our findings

One relative told us, "We are confident he is safe and well cared for. They have provided alarm sensor mats so they know if he has moved." Another said, "She is definitely safe. They notice if she is unwell at all."

External professionals we spoke with raised no concerns about people's safety. We asked a range of people about levels of staffing at the service and there was a consensus that, whilst staff were sometimes rushed, there were sufficient staff on duty to keep people safe. The provider had in place a tool to calculate the levels of staffing required, based on their dependency levels. They acknowledged the tool was useful to give them indications of how many staff were needed but that unexpected sickness absences sometimes meant staff were under additional pressure. Staff we spoke with also stated there were generally sufficient staff, although when there was an unexpected absence, or when they were reliant on agency staff, this made the role more difficult. The registered manager was currently recruiting more staff in a bid to reduce the impacts of unexpected staff absences.

One relative told us, "I am confident he is safe here. He has not had any falls since he came here and he had several at the last home."

We looked at how staff helped protect people against the risks they may face, such as falls or weight loss. Individualised risk assessments were in place detailing what the risks were, when they might be most prevalent and what staff could do to reduce those risks. Staff we spoke with demonstrated a good awareness of these risks.

Staff used recognised tools to help staff identify risks in people who may not be able to verbally communicate, such as the Abbey Pain Scale and the Cornell Scale. The Abbey Pain Scale is a means of assessing pain in people who are unable to verbally articulate their needs, for example by documenting facial expressions. The Cornell Scale is used to help identify when someone living with dementia may be suffering depression. These tools had been completed regularly and reviewed.

Where one person presented a specific risk to others we saw that staff completed observations every 15 minutes and other adaptations were in place to alert staff to when the person had moved. The registered manager was regularly liaising with a range of external healthcare professionals to assess this person's needs and risks on an ongoing basis, and to put in place one-to-one support. They agreed they could improve the level of information they were able to share by documenting additional details in these 15 minute observations.

We found medicines were administered safely. Medicines records we sampled were accurate and medicines were stored appropriately in line with guidance. Temperatures of the treatment room was regularly recorded and within safe limits whilst disposal of medicines processes were clear.

We sampled a range of Medicine Administration Records (MARs) and found them to be in good order, containing photographs and information about people's allergies. Sample signatures of staff were available,

making auditing and error identification easier. Staff had their competency with regard to administering medicines assessed annually. We checked controlled drugs and found these were stored in line with good practice. A sample check of stock identified no errors. Controlled drugs are medicines liable to misuse.

Body maps were in place to ensure staff administering medicines in a cream format knew how and where to apply these medicines. Staff demonstrated a good knowledge of people's medicinal needs and there was regular oversight from senior staff, with the registered manager auditing medicines on a monthly basis. This meant people were not placed at risk through the unsafe administration of medicines.

We observed nurses communicating well with people during the inspection and seeking consent before administering medicines. Likewise staff sought consent prior to helping people mobilise and we observed safe moving and handling practices throughout.

The registered manager and other staff were able to demonstrate how they had learned from previous incidents. A concern had been raised about moving and handling practices in the home earlier in the year. We saw the registered manager and area manager had acted promptly to ensure all staff were consistent in how to identify and raise concerns in the future. They did this through arranging retraining in moving and handling and ensuring key messages regarding safeguarding were delivered at team meetings and in individual supervision meetings. We saw all staff had received safeguarding and whistleblowing training and, when we spoke with them, they were confident in what to do should they have concerns. This meant senior leadership in the organisation had responded appropriately to ensure staff responsiveness to concerns was consistent and helped keep people safe.

Accidents and incidents were documented on the service's electronic data management system, which automatically flagged significant concerns to the registered and areas managers. We found this system to be working well and that accidents and incidents had been appropriately reviewed.

Pre-employment checks including Disclosure and Barring Service checks, identity checks and references had been made. This meant that the service had a consistent approach to vetting prospective members of staff to make sure they were suitable.

Maintenance records showed that relevant equipment had been regularly serviced and checked, for example emergency lighting, fire detection and fighting equipment, gas and electrical installations. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

Access to the home was through a locked door and visitors were asked to sign in, whilst the rear garden area was enclosed and secure.

With regard to infection control we saw the registered manager planned to have a champion in place, which is good practice to ensure improvements can be sustained and standards maintained. We found the service was clean throughout, including the laundry, which had been disorganised at the last inspection. This meant the service managed the risk of acquired infections.

Requires Improvement

Is the service effective?

Our findings

People who used the service were supported by staff who received a range of relevant training and demonstrated the skills necessary to meet their needs.

At the last inspection staff had received the provider's 'PEARL' training (Positively Enriching And Enhancing Residents' Lives). At this inspection the registered manager acknowledged they required a more dementia-specific training model and had recently introduced the provider's Dementia Framework. Staff we spoke with were positive about the knowledge this course had given them so far and also the practical side of the training, such as a session whereby they learned to understand what it might feel like to move around an unfamiliar environment with sensory loss.

We reviewed the registered manager's training matrix and found staff had been trained in core topics such as safeguarding, infection control, dementia awareness, moving and handling, first aid and fire safety. We established that a number of people who used the service could present with behaviours that staff found challenging, for example the potential for physical aggression. Staff we spoke with demonstrated a good awareness of how to anticipate these behaviours and how to use distraction methods to ease people's anxieties. No members of staff had however received breakaway training to ensure they kept people who used the service, and themselves, safe, should these de-escalation strategies not work and there be a need to remove themselves from a more physical altercation. The registered manager and area manager acknowledged this was an area of training they had planned to deliver to staff but, as yet, had not been able to do so. They agreed to ensure this training was delivered as a priority.

The premises were generally suitable and appropriate for the needs of people who used the service, with well-lit corridors, ample bathing and toileting facilities, multiple lounge areas and a well maintained enclosed rear garden. Some people had pictures meaningful to them on their doors, whilst others had memory boxes containing photographs and other memorabilia. Some corridors benefitted from tactile decorations and murals. We found the male-only area of the home however required attention to ensure it was more dementia-friendly and in line with people's needs and preferences. For example, the majority of people living in this area of the home had a previous keen interest in various sports, but there was little effort to incorporate this into the environment or activities planning. Likewise, the dining area had plain painted walls with little decoration. More generally, some signage could also be improved, for example to indicate to people which direction to follow the corridor in order to get to the dining room. The registered manager and area manager told us they planned to refurbish the male-only area and agreed to make it a priority.

Nursing and care staff consistently demonstrated a good knowledge of people's needs and how they helped them. We saw a range of evidence that demonstrated staff liaised with external professionals to ensure people's primary healthcare needs were met. For example tissue viability nurses, dietitians, speech and language therapy (SALT) and doctors. We saw advice from these professionals was incorporated into care planning documentation.

Feedback from external professionals was mixed, with one telling us, "It can be up and down. The regular

nurse is great but if they are relying on agency staff then sometimes that knowledge drops off. Generally they're okay though."

Staff were supported by receiving regular supervision meetings and appraisals. A supervision is a discussion between a member of staff and their manager to identify any areas of concern or training needs. Appraisals are an annual review of performance. We saw these meetings were themed to ensure staff had regular discussions about core topics such as safeguarding and moving and handling, and that the registered manager planned these meetings in advance. Staff meetings were also held regularly and we saw they had set themes to ensure the registered manager gave a consistent message regarding, for example, positional changes or hydration. We observed a handover between shifts and saw staff were able to pass on detailed information about people's fluid intakes and health and wellbeing generally. This demonstrated staff received good levels of support and consistent, key messages from the registered manager.

People who used the service were complimentary about the meals they chose. One person told us, "I get four good meals a day and plenty to drink." Another told us, "It's lovely." When we spoke with the cook they demonstrated a detailed knowledge of people's preferences and dietary needs. Five members of staff had expressed an interest in becoming nutrition champions.

We observed two lunchtimes. One service was calm, with ample staff in place to support people and choices clearly given. We found however one mealtime we observed to be more chaotic. Staff members told us they were able to manage the workload but we found people some people had to wait for their meal. Staff interacted well with people but, during our observations, did not have time to adequately cater to all people's preferences. The lunchtime service on the first floor was in a dining room that could not accommodate all people who lived on that floor at once. Accordingly, we observed five people sat in the adjoining lounge waiting for there to be sufficient space in the dining room to have their meal. We fed this back to the registered manager and provider, who agreed to review the lunchtime experience on the first floor and how staff were deployed to support people.

We observed people being offered drinks and snacks from a trolley throughout our inspection. This meant people were supported to maintain a healthy, balanced diet.

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 in their best interests and as least restrictive as possible.

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).

We saw appropriate applications had been made to the local authority and staff we spoke with demonstrated an understanding of the principles of the MCA. Where decisions were taken in people's best interests because they lacked capacity, for example the use of a lap belt on a wheelchair, we saw this was assessed as the least restrictive option and in order to keep people safe.

'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) documents were in place and appropriately documented. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people's needs had been reviewed appropriately.

Good

Is the service caring?

Our findings

People who used the service told us they were treated well by members of staff and that they enjoyed living at the service. One person told us, "I have been here nearly two years and I am very well looked after." We observed people interacting positively with staff throughout the inspection.

Where people were known to have particularly anxious behaviours we saw staff interacted with them in a compassionate way and distracted them from these anxieties by, for example, asking if they wanted to go for a walk or to take part in an activity. When we spoke with staff they demonstrated a good knowledge of people's individualities and how best to support them.

Relatives we spoke with were consistently positive about the standards of care at the service. One told us, "There is just a lovely caring atmosphere here. He is always clean and well dressed and they always do such a good job in the laundry." Another said, "The staff are great – they encourage him to do things for himself. The staff have got to know him well even after just a couple of months."

Another relative said, "The staff are sound – they are very understanding and caring." External professionals we spoke with were complimentary about staff conduct and the atmosphere at the service. Likewise, external feedback was displayed at the entrance to the service from recent surveys. These contained further positive feedback about the service. One thank-you care read, "Thank you for the way in which you looked after my auntie during the years. She was cared for with love."

Whilst people had a wide range of needs and at times anxieties, we found the atmosphere to be calm at all times during the inspection. People's rooms were personalised with photographs and mementos.

Staff generally interacted very well with people who used the service, sharing jokes where appropriate and behaving patiently with them. We observed staff accepting physical contact such as holding hands and hugs to ensure people were emotionally supported. We observed one instance of interaction between a staff member and a person who used the service which was not dignified and fed this back to the registered manager. All other staff interactions we observed however, at all levels of staffing, were caring.

We found people were well dressed, clean, with their hair styled as per their preference and interacting calmly with staff.

Staff respected people's dignity, lowering themselves to eye level when speaking with people who were sat down, and explaining where they were going with people, or how they intended to help them. Communication was geared to the needs of the person who used the service. Staff told us the training day they had spent experiencing sensory losses and other associated symptoms of dementia-type illnesses had helped them gain additional insight.

We saw information regarding advocacy services was readily available, whilst people who used the service were supported by formal advocacy services and, for the most part, relatives who knew them best.

We saw people were asked about their religious beliefs and end of life care preferences, and that these were accurately documented in people's care files.

People's confidential information was securely stored in a locked office.

Good

Is the service responsive?

Our findings

The majority of people who used the service and relatives we spoke with were content with the level and range of activities available. The service had a full time activities co-ordinator in place and they demonstrated a range of ideas about prospective activities to try. For example, they had trialled using virtual reality headsets on one occasion and stated this had been popular with some people. They had also tried pet therapy and had ordered products that used smells and music to evoke memories of popular places, such as 'forests' and 'British gardens'. This had yet to be trialled. They had also made contact with local schools and a local tea room to improve relationships with local groups to ensure there were opportunities for people to feel a part of the community.

There were weekly activities planned and these were mostly group-based, along with intermittent outings in the minibus, which was shared with two of the provider's local homes. Regular activities included bingo, hairdressing, manicures, hand massages, dominoes and entertainers such as singers. When asked about activities provision specific to the male-only area of the home there were plans to put up nostalgic images on the walls but, as yet, no specific plans for person-centred activities for this area of the home. The registered manager acknowledged that activities provision and planning needed to be person-centred and therefore activities needed to be planned in line with the preferences and personal histories of the men living in this area of the home. We saw one of the service's iPads was used so that one man could watch one of his favourite films, South Pacific. This had not been planned but demonstrated a good use of new technologies. The activities co-ordinator agreed they could better plan the use of such technology to help people access activities meaningful to them.

We did see other instances of person-centred care being well delivered. For example, one person's life history meant that they found particular comfort in using an empathy doll. The person's relative was positive about this, stating, "They are pro-active and responsive to her needs. They noticed her cuddling things and recommended we tried an empathy doll, which she seems to be benefitting from."

People's changing healthcare needs were well monitored and managed. We saw evidence of monthly care plan reviews and regular multi-disciplinary reviews where people's needs required further support. One person's relative told us, "They arranged for additional staff to support her changes in terms of needs – she has now got one-to-one support." Another person's relative said, "They ring me if there is any problem – they always notice if he is under the weather." This meant people's changing health needs were met and relatives were included in the reviews of people's care needs.

There was a preadmission assessment in each care file, which detailed people's medical, dietary, religious, mobility and other needs. Care files contained good levels of person-centred information and were accurate, contemporaneous and easy to follow.

At the time of inspection the activities co-ordinator was reviewing and adding extra detail into people's 'My Choices' booklets. These contained additional information about people's likes, dislikes, personal history and other information, for example their favourite music or films. This meant the service had regard to the

information and preferences that made people individual and also updated this information during people's time at the service.

Staff demonstrated a good knowledge of people's backgrounds and preferences, as did the activities co-ordinator, and the registered manager agreed to better use this knowledge to plan activities in the male-only area.

The service used an iPad in the entrance foyer, with the intention that relatives and other visitors could provide feedback about the service. Staff were also to use the iPad to gather feedback from people who used the service on a regular basis. Feedback we reviewed was wholly positive. The registered manager showed us the dementia-specific version of the survey that staff were now using. This had an early question which asked whether or not people could answer questions about the standards of care. Where they were unable, the survey automatically directed staff to conduct observations as a means of gathering information about the experiences of people who used the service. This meant the registered manager was aware of the need to tailor the way they assessed care provision to ensure people who were not able to express their own views were included.

We saw the registered manager had responded to complaints in line with the provider's policy, giving clear outcomes to complainants. Complaints were analysed in case there were trends or patterns developing. All relatives we spoke with knew how to raise concerns and complaints if they needed to and we saw the complaints policy was readily accessible in the service. This meant people could raise concerns and that these concerns or complaints would be dealt with.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care. They had been at the service for just under a year and had a good knowledge people's care needs, likes and preferences, as well as the day-to-day workings of the service and the governance structures in place.

The registered manager had to complete a range of reports for the area manager each week. The area manager demonstrated a strong awareness of the importance of the content of these reports and demonstrated they ensured the registered manager was accountable for the content. These included, for example, reports on recent accidents or incidents, staffing levels and levels of training completed by all staff. We found this additional level of scrutiny meant gaps were highlighted and addressed.

The registered manager and other staff completed a range of auditing, such as medicines audits, environmental checks of the service, care plan audits and people's weights. They undertook a monthly safety tour of the building and monthly bed rails checks. These checks and audits meant errors were identified at an early stage and improvements made.

Staff we spoke with were all complimentary about the impact of the registered manager. They told us, for example, "She's had to deal with a lot and she does it fairly. I can always come here [the manager's office] for advice," and, "They are a good leader." Relatives we spoke with also spoke positively about the levels of communication they had with the registered manager and other staff and, during the inspection we observed the registered manager interacting compassionately and knowledgably with people who used the service. This demonstrated they were able to balance their governance responsibilities alongside providing hands-on leadership.

The service provided care and accommodation to people, the majority of whom were living with dementia. The registered manager had the relevant experience and was implementing changes that would tailor the service more towards benefitting people with dementia. This included dementia-specific approaches to completing the provider's survey and the planned introduction of dementia and dignity champions. This is considered good practice. They had a clear vision for how improvements could continue to be made over the next eighteen months and were receptive to feedback and areas of best practice.

Resident and relative meetings had happened, although not regularly, and they were not well attended. The registered manager had trialled a 'cheese and wine' evening to make the meeting less formal, and found this had brought limited success. They told us they would continue to trial ways of encouraging more involvement in how the service was run from people who used the service and their relatives.

One external professional told us, "I've always had positive dealings with them." They told us how, as soon as the manager had been made aware that a piece of equipment had not been ordered by staff, they took immediate action.

Documents we requested and viewed during the inspection were readily available and well organised. They were easily accessible for scrutiny or review of audit trails that may be required. The provider ensured audits of the service took place annually. A recent local authority visit to the service had raised no concerns about care provision. This meant the registered manager could demonstrate how the service was performing and how people's needs were being met to a variety of internal and external stakeholders. Policies were regularly reviewed and we saw key information such as safeguarding procedures, complaints procedures and the previous CQC report were displayed in communal areas. Appropriate notifications had been made securely to CQC in a timely fashion regarding a range of incidents.