Brunelcare

Robinson House Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 16 and 17 March 2015 and was unannounced. Robinson House provides accommodation for up to 70 people who require nursing or personal care. There were 67 people living in the home on the day of our inspection. The home specialises in providing a service to older people who are living with dementia. At our last inspection on 18 December 2013 there were no breaches of the legal requirements identified.

A registered manager was in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirement of the law; as does the provider.

Medicines support plans were available to enable staff to have a good understanding of the medicines they were administrating. However, hand-written administration charts had not been signed by two staff to minimise the risk for medicines errors.

Summary of findings

Staff responsible for administering medicines had not maintained their skills and had not received regular updates of their knowledge and skills. We observed a specific medicine was not administered correctly. Some people did not receive their morning medicines at the correct time although they were recorded as having been given at 8 am. This could mean that some medicines could be ineffective and could be a risk to the wellbeing of the person.

The people we spoke to told us that they were well supported in their home and felt safe and happy. Staff completed risk assessments to help minimise risks for people. The equipment used was serviced and checked regularly by staff. There were policies and procedures to guide staff in how to keep people safe and staff had completed safeguarding training.

There were various quality assurance systems in place. These included audits, house checks and through regular discussions during the annual support plan review. The home was found clean, hygienic and well maintained.

People and their representatives and others were asked for their views about their care and support and they were acted on. When people were unable to make their own decisions, staff consulted with appropriate people and planned care in the person's best interest. People were registered with a doctor, dentist and an optician to ensure their health was monitored.

Staff demonstrated an awareness of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation is intended to ensure people receive the support they need to make their own decisions wherever possible. When restrictions were placed on people's liberty, the registered manager ensured this was authorised legally by the local authority.

People were supported to make choices around the care they received. People's nutritional needs were met and they told us they liked the meals provided; there were lots of choices and alternatives to the main menu.

Each person had their own weekly activity planner in their support plan. The staffing levels were safe and met the needs of the people who used the service. Health and social care professionals told us they had no concerns about Robinson House.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Medicines support plans were available to enable staff to have a good understanding of the medication they were administrating. However, hand-written administration charts had not been checked for accuracy.

Staff were recruited safely and received training to help safeguard people from abuse.

Staff completed risk assessments to help minimise risks to people who used the service and equipment was maintained appropriately.

Systems were in place to reduce the spread of infection

Requires improvement

Is the service effective?
The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. When restrictions were placed on people's liberty, the registered manager ensured this was authorised legally by the local authority.

Staff gained consent to the care they delivered to people. When people were unable to provide consent, they discussed this with family and professionals to plan care in their best interest.

People's health care needs and nutritional needs were met; menus showed that people were provided with a variety of meals and alternatives.

Staff received induction, training, supervision and support to enable them to feel confident when supporting people to meet their needs.

Good

Is the service caring?
The service was caring.

Staff interacted with people who used the service in a positive way.

Staff promoted choice, privacy and dignity and encourage people to be independent.

People were provided with information to enable them to make choices and were included in decisions made about their care

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People who used the service had assessments of their needs and plans of care that were person-centred. These provided staff with guidance in how to support people's needs, preferences and choices.

There was a programme of activities for people to participate in within the service and in the community.

The service had a complaints procedure, responded to complaints and investigated them appropriately.

Is the service well-led?

Good

The service was well led.

The quality of the service was monitored by audits and seeking the views of people who used the service, their relatives, staff and visiting professionals.

Staff communicated well with the registered manager they felt they were well supported to carry out their roles and responsibilities.

The registered provider had a mission statement and a set of values which guided staff in their practice. Staff knew the ethos of treating people as individuals and improving their quality of life.

Robinson House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 March 2015 and was unannounced. The inspection team comprised three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At our last inspection on 18 December 2013 there were no breaches of the legal requirements identified.

Before the inspection we looked at the information we held about the service including notifications they had sent us.

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.

On the day we visited, we spoke with 15 people living at Robinson House, five relatives, 10 care staff, five nurses and the registered manager. We observed how the staff interacted with people who used the service. Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked around the building. We looked at a sample of 10 records of people who used the service and three staff records. We also looked at records related to the management of the service.

Following our visit we spoke with three health and social care professionals, who were involved in the care of people living at the home.

Requires improvement

Is the service safe?

Our findings

Medicines support plans were available to enable staff to have a good understanding of the medication they were administrating. However, hand-written medicines records administration charts had not been signed by two staff. This practice is designed to minimise the risk for medicines errors.

Staff responsible for administering medicines had not maintained their skills and had not received regular updates of their knowledge and skills. One person was offered their inhaler in the middle of breakfast incorrectly by a staff member. It was noted on the MAR chart as a correct administration. When we asked about any training on techniques of administering the particular medicine the staff member told us they were not aware that the medicine was administered incorrectly and have not received updates.

Some people did not receive their morning medicines at the correct time although they were recorded as having been given at 8am. We observed morning medication rounds started around 900 am and finishing just before lunch. This presented a risk that some medicines could be ineffective and could be a risk to the wellbeing of the person.

Staff told us that no-one was able to look after their own medicines. All medicines were looked after and given by staff. We saw some people being given their morning and lunch time medicines by the registered nurse and a senior care worker.

Not all medicines were given the correct way. Some people were prescribed with certain medicine for treatment of particular health condition. The medicine was usually administered once weekly and it needed to be given on an empty stomach at least 30 minutes before breakfast. Staff told us that it was given by the night staff first thing in the morning before they finished their shift which would be in excess of 30 minutes before they had their breakfast.

Suitable storage arrangements were in place for medicines. Records showed that medicines were stored at a safe temperature. Medicines requiring additional security were stored correctly and records showed they had been looked after safely. However medicines awaiting disposal were not stored securely and could be accessed by unauthorised staff. We discussed this with the registered manager at our feedback session. They told us they would ensure this was addressed at the staff meeting.

Some medicines were administered covertly. Brunelcare medication policy stated that the use of covert administration needed agreement by the person's GP, the person, or their representative if they do not have the capacity to consent. However, the nursing staff told us they did not think that the current practice of using thick and easy and the like to assist people to swallow their medicines fell under covert administration. Staff had not followed the covert administration policy and there was no evidence that staff had checked with the pharmacist whether it was safe to give these medicines using this method.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Suitable arrangements were in place for the ordering of medicines. Records showed that people's medicines were available for them. The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines.

Significant incident of medicines error was reported. One recent incident report happened in February 2015 and the registered manager told us they would conduct an enquiry with written report of the findings sent to the senior management team .This would enable the home to learn from the incident and to prevent the incident from happening in future to keep people safe.

People and their relatives were positive about the staff team and the care and support they received. One person said "I feel safe and secure." A relative told us "I trust them to do what's right. I believe my family member is safe here".

People were protected from the risk of abuse. The home provided training to all staff on protecting people from abuse. This was refreshed in their annual training programme. Staff told us they had received training in safeguarding people. They were clear about the action they would take in event of a concern about someone's safety. One staff member said: "we are working with vulnerable people; you have to report anything that could harm them." Staff expressed their confidence in registered manager taking action to make sure people were safe if they had any concerns.

Requires improvement

Is the service safe?

The registered manager responded to any allegation of abuse. Records showed that the home had responded appropriately to any issues of concern. Health and social care professionals spoken with confirmed there were no concerns about the welfare of people in the home. They told us they had confidence in the service and in staff practices within the home. One health professional told us “I have no concerns about the people living there”.

People were protected against the risk of unlawful or excessive control or restraint. The service did not use any form of restraint. However risk assessments were in place for those at risk of falling out of bed. We saw that agreements were in place and bed rails were used where it was assessed as necessary to keep people safe.

Risk assessments had been completed for each person, depending on their specific circumstances. The risks assessment related to nutrition, moving and handling, falls and skin integrity. Risk assessments had been reviewed at least monthly, and more frequently, where risks changed. Risk assessments on falls prevention were also in place where relevant, and equipment was used to transfer people safely Staff had good knowledge about people’s needs and the level of support they required to keep people safe.

Accidents and incidents were reported and recorded and assessed by the registered manager to minimise the risk of it happening again. For example where there was a pattern of falls, referrals were made to relevant professionals for advice and care plans were reviewed.

People were protected from unsafe or unsuitable equipment. Records confirmed that fire- fighting equipment and emergency lighting was checked regularly to make sure it was working and safely maintained. All portable electrical appliances were checked and tested annually. There were procedures in place in the event of an emergency for example a fire, ill health, extreme weather conditions or a virus outbreak and the home had to close. Staff were aware of this.

There was enough qualified, skilled and experienced staff to meet people’s needs. Staff attended people’s needs in good time and no concerns were raised about the quality of the care. None of the people we spoke with had concerns about staffing levels. A person said they had used their call bell at night when they felt unwell and a staff member came to help them very quickly “they were there just after I pressed it. A relative told us they observed how attentive staff were during the day, they said "there is always a member of staff at hand to assist; they are obliging and very helpful.

The registered manager told us that the normal staffing ratio was an average of 18 staff on duty including two registered nurses across the day time hours. On the day of our visit there were 20 staff in the morning and 16 staff in the evening. Nights were covered by six care staff, and two registered nurses. In addition to the nursing and care staff a clinical lead and the registered manager were available to oversee the day to day running of the service. Each person using the service had been risk assessed to determine their level of dependency. People’s level of dependency was reviewed on a regular basis to ensure it accurately reflected the level of support the person required. We looked at the staffing rota and found this was in accordance with the number of staff on duty. Staff confirmed that staffing levels were normally maintained. These were sufficient to meet the needs of the people using the service.

There were appropriate recruitment and selection processes in place. This included completing an application form and attending an interview. This enabled checks to make sure that staff were fit and had the right qualifications, skills and experience to care for the people at the home. All of the three staff files contained a completed application form, proof of their identity and evidence of either a Criminal Records Bureau or Disclosure and Barring Service check. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. They also contained details of people’s qualifications, training and experience. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom. Staff confirmed that they had an interview and that checks and references were taken before they started work.

People were cared for in a clean and hygienic environment. General cleaning was being carried out throughout the inspection by the domestic staff. All rooms were clean, tidy and free of clutter. All showers, toilets commodes were cleaned thoroughly each day. Daily records of cleaning were kept and where equipment was identified as at risk of wear and tear or damage arrangements were in place either to repair or replace them.

Staff washed their hands after attending to people’s care. This helped to reduce the risk of cross contamination and

Requires improvement

Is the service safe?

promote infection control and cleanliness. There were hand sanitizers at various locations throughout the building. Appropriate notices were found in areas of the building stressing the importance of hand hygiene. Staff used personal protective equipment, aprons and gloves to help to prevent the risk of cross infection to the people, staff and visitors.

There were up to date policies and procedures relating to cleaning and infection control and we noted that all staff undertook training in infection prevention control.

Good

Is the service effective?

Our findings

New staff told us they received support and guidance since they began working in the home. A member of staff told us that, this was their third day at Robinson House. They commented that "Staff had been very friendly; helpful and supportive.

All staff spoken with told us that they had received a comprehensive induction that gave them the skills and knowledge to carry out their role. As part of their induction they had completed the organisations own induction programme and a local induction at Robinson House. The induction included undertaking shadow shifts with an experienced member of staff before working as a member of the team. They told us that the support they had received had prepared them to carry out their role. One staff member told us ""I have been really well supported so far. I've had a six day induction programme, covering policies and procedures, and now I am shadowing another nurse. I've been told I can continue to be supernumerary.

Staff received training relevant to their roles. Training included manual handling, communication, safeguarding vulnerable adults from abuse, first aid, fire safety, health and safety, Control of Substances Hazardous to Health (COSHH) and infection control. Trained nurses undertook more specific training required to meet people needs. These included venepuncture, using syringe drivers and dementia awareness. Staff confirmed that they were able, from time to time, to obtain further relevant qualifications, including previous National Vocational Qualifications (NVQ) or the current Qualifications and Credit Framework (QCF) diploma. This provided them with relevant qualification to perform their roles effectively. A member of staff said that, "working here is good as there is a lot of training and good opportunities to help your carer".

Staff were able to tell us when people were becoming unwell, and took prompt and appropriate action. We saw that the GP was asked to visit people if people felt unwell. The GP visited the home weekly and held surgeries there. Health professionals told us staff responded to emergency situations such as arranging for people to be transferred to hospital as necessary.

People were provided with food and drinks that met their needs. At lunch the menu offered variety of nutritionally appropriate meals. There was a range of hot meals served from a hot trolley to keep the food at a right temperature to meet people's needs.

At the start of mealtimes individuals were asked about their preferences and they were served their preferred meal from the selection. We spoke with a group of people who sat at a dining table. They said," the food is lovely and tasty." Another person said, "the meals are good here you get plenty of choice." Another person said, "There are always two choices and if I don't want them I can have an alternative." We saw that people eat at their own pace and staff did not rush them.

People were supported to eat and drink. At lunchtime in the four dining areas staff provided people with drinks and supported anyone who needed assistance in a positive manner. People unable to eat independently were assisted appropriately. Staff sat with people while assisting with eating, they were encouraging and engaged with people through eye contact and body language. People who chose to remain in their beds were made comfortable and assisted to remain independent by eating at their own pace. There were drinks provided on a regular basis in the lounge areas, and in the bedrooms for those remaining in bed. Staff were seen frequently encouraging people to drink fluids. This helped reduce the risk of people becoming dehydrated.

The catering staff described how they oversaw the catering arrangements at the home. The catering staff demonstrated a good understanding of the different diets needed, such as for people with diabetes and those who needed a soft diet. Soft diets looked appetising and well presented. Staff asked people if they wanted a drink or a snack between meals. There were also kitchenettes where drinks and snacks could be made by staff or visitors.

People's food and fluid intake were monitored to ensure they had sufficient for their needs. All of the intake charts had been completed and were up to date. For example, one person's whose dietary needs had changed was assessed as needing a pureed diet and this was clearly indicated within the plan. The guidance for staff had also been personalised and detailed that the person should be assisted to eat the pureed food using a long specialist adapted cutlery due to their medical condition.

Good

Is the service effective?

Records showed people's weight had been monitored regularly to help ensure they maintained a healthy lifestyle. Where any concerns were found action had been taken, for example we saw GP's, dieticians and the speech and language team had been involved as required. People who were at risk of poor nutrition or dehydration had a nutritional screening tool in place which indicated the level of risk and what to do to minimise the risk.

Staff responsible for gaining and reviewing consent from people about their care and treatment had an understanding of the Mental Capacity Act 2005 (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. All of the staff told us they had completed training in the MCA and training records were provided, which reflected this. This ensured that the staff had the information they needed to ensure decisions were made in people's best interests.

Before people received care they were asked for their consent and the staff acted in accordance with their wishes. Care plans showed that people were consulted about their care with regard to their preferred daily living routines and choices. People or their relatives had also signed their consent to the arrangements for their medicines, the circumstances for sharing their personal data with others and their photographs for identification purposes. People's care plans were regularly reviewed with them, their relatives and professionals concerned with their care when required.

Where people did not have the capacity to consent, we found the provider acted in accordance with legal requirements. One person's capacity to consent to their care was sometimes changeable because of their medical condition. Staff, were able to describe how they assessed this person's capacity to make decisions about their care. Care records accounted for the types of decisions they were able to make and the circumstances under which decisions were made in their best interests.

Records showed that the registered manager had followed the correct procedures to ensure any restrictions, to which a person was unable to consent, were legally authorised under the Deprivation of Liberty Safeguards (DoLS). They aim to make sure people who lack mental capacity are looked after in a way that does not inappropriately restrict their freedom. The safeguard require that a care home or hospital only deprives someone of their liberty in a safe, correct way. It is only done in the person's best interests and where there is no other way to look after them to keep them safe. The registered manager told us that 66 applications had been submitted to the local authority and one had been authorised to keep the person safe.

Policies and procedures were in place to provide guidance for staff about their responsibilities under this legislation. Staff were able to give us examples of the day to day decisions they supported people to make. For example the clothes people chose to wear or the food they wanted to eat.

People's care plan records showed where someone had a legally appointed person to make decisions for them. Information was held about the sort of decisions they were authorised to make, such as their finances. This ensured that the right person would be contacted if a decision needed to be made on behalf of someone receiving care at Robinson House

People's care records supported advanced decisions that each of them had made about their own care and treatment, in the event that they may need emergency resuscitation due to collapse. This was important if a decision was required about whether the home's staff or emergency services attending a person at the home should attempt to resuscitate them in the event of an emergency.

Good

Is the service caring?

Our findings

People and their relatives said they were happy with the care provided. One relative told us, “It’s brilliant here, excellent, staff are welcoming and they treat my relative, and everyone else, like a person.” Another person was very complimentary about the staff and care. They told us “we are very happy with mum’s the care.”

Staff were positive about the quality of care they delivered as a team at Robinson House. We observed staff interacting with people in a kind and caring manner; people were not rushed, staff used their first name, and were gentle in their approach when they assisted people. The atmosphere was generally calm, and call bells were answered in an acceptable time scale. We heard staff complimented people as they passed them. For example, we heard one staff member told somebody their hair looked very nice, and asked if they had been to the hairdresser, and on another occasion, two members of staff assisted someone and complimented them on their new footwear.

Staff knew the needs of people they were caring for. Robinson House had two floors and were divided into four units. Staff told us that they worked in the same unit. This meant that people received continuity of care with staff they were familiar with .Staff told us about the different needs of people. One staff member said “I know them all so well now. The longer I work here the more I know about people”. Another staff member said "We do actually care here, we want to make the people who live here happy, and continuity of care helps us to do that”.

One person who was becoming distressed and was asking to leave the building. A member of staff noticed this and responded quickly, encouraging the person to go for a walk in the garden with them. Another member of staff told us “X does become a bit upset sometimes, but we can calm them down and reassure them by taking them for a walk. I know this because I know them so well, and staff share this knowledge with each other”.

People had signed to confirmed they agreed with their care plan of care. Where people were unable to participate, relatives had been involved in discussions. We saw that relatives had signed plans to indicate their agreement. One member of staff told us “The relatives know the person really well, so it’s helpful to get their involvement. The more they tell us, the better the plan of care”.

Several of the room doors people resided in were closed. Staff told us that some people chose to remain in their rooms. We spoke with one person who told us “I prefer to stay in my room, I have my own things around me, and my television, I’m happy”. Staff were aware of people who preferred their own rooms to spending time in the communal lounges. Staff offered people the choice of where they would like to go. For example, staff asked people if they wanted to go to the dining room for lunch or if they wanted to eat in their room. Staff assisted people to the communal areas. Some staff asked people where they wanted to sit. One staff member told us “X is nursed in bed, but I try to make the time to go and have a chat with them, take them a cup of tea. Even if it’s just for five minutes, people love to talk”.

Some people told us that they could choose when they wanted to get up and go to bed, or if they wanted to go to the lounge or not. We observed people were asked and being taken back to their room from the lounge. .

People's diversity was respected. Staff were aware of people’s religions and their preferences about practising their faith. People had the opportunity to follow their religion. For example an individual was provided with a copy of the bible as requested. One staff member told us “We are trying to get someone from the church to come in, which would be good”.

The staff described their knowledge of individual needs and how they promoted people’s independence. We saw people who were at risk of falling being assisted by staff to move between rooms in a manner that gave them security and confidence. We saw that people who preferred to remain in their rooms were checked on regularly to ensure they were not isolated.

People’s dignity and privacy were maintained. All personal care was delivered behind closed doors. Staff knocked before entering people’s rooms and staff were knowledgeable about how to maintain people’s privacy and dignity. Staff gave examples such as “We always close the door when helping wash people” and “I keep people covered up during personal care”. Staff told us they had received training on maintaining privacy and dignity.

Within the care plans people’s preferences and choices for their end of life care had been documented where they had been discussed with the person and/or their relatives. People’s preferences in relation to hospital admissions had

Good

Is the service caring?

been documented. The registered manager told us they were working towards achieving accreditation for the Gold Standards Framework (GSF) for Care homes this year. The GSF is a national framework that helps doctors, nurses and healthcare workers to provide the highest possible standard of care to people who are in the last years of life. The staff were knowledgeable about the GSF and discussed the paperwork that had been implemented so far that helped with this planning.

There positive interaction between staff and people as well as visitors to the home. Staff engaged people in conversations and enabling them to be as independent as possible, while providing support and assistance where required. For example, we saw staff helping people to eat their meals and treated them with respect.

People were given choices about how they spent their time and people were relaxed and comfortable with staff. In the lounges we saw the variety of options available. Staff were responsive to people's emotional needs; one person who showed initial signs of distress was calmed by the gentle manner of the member of staff who offered a soft toy. The person responded with a contented smile.

Staff understood the need for confidentiality with regard to people's care and we saw that they were provided with policy guidance about this. This meant staff had the information they needed to understand how to manage confidential information. For example, one staff member told us "I will not disclose the personal details of a resident on the phone. I will always ask the person to speak to the manager".

Good

Is the service responsive?

Our findings

People's needs were assessed and care was planned according to their individual needs. When people were admitted thorough assessments were completed that identified all areas of need. Care plans had been completed and reviewed monthly. In one person's plan staff had documented that they become anxious and distressed during personal care. Staff had documented that providing personal care in the bathroom rather than the bedroom helped to alleviate their distress. This care plan was reviewed in February 2015 and had advised staff should continue to follow the present guidance to ensure the needs were met.

People's care files contained "This is me" booklets. These booklets were devised by The Alzheimer's Society. These are aimed at enabling health and social care professionals to see the person using the service as an individual in order to improve person centred care. Of the eight booklets we looked at, five were fully completed and gave staff comprehensive information about the individual they were caring for. The remaining three were still being completed as information was still being gathered about the people to enable staff to meet their needs.

Risk assessments within the plans had been completed. For example, there were risk assessments for the use of bed rails moving and handling and malnutrition. These risk assessments had been reviewed and the care plan updated. One plan showed that staff had highlighted the risk of malnutrition and a plan had been put in place to address this. In another staff had documented person's weight gain. Another plan stated that a person was assessed as a high risk of falls and there was a care plan in place to support their mobility.

People and their relatives understood the care and treatment choices available to them. People said staff explained to them what services were provided when they came to live in the home. They told us the services available such as the GP visits, the chiropodist and dentist were made clear in the beginning. They said they were asked questions, such as their preferences and routines, times for getting up going to bed. They said routines at the service were tailored around their needs and wishes

Care records contained evidence of interaction with other healthcare professionals such as a GP or tissue viability nurse. Communication with family members was also documented. People experienced person centred care. For example one member of staff told us "It's important to make the care about the person's needs, to offer choices" and "It's important to help improve people's quality of life".

People took part in activities that suited their needs. Some of the staff had been trained to provide Oomph sessions to people, which involved light exercise to music. There was an activities coordinator employed to coordinate activities and visits to local facilities. Both the activities co-ordinator and the registered manager described the various activities available to people. There were activities usually one on each week day as well as one to one sessions for people who were unable to participate in the group activities. The registered manager said that they were recruiting a second activities co-ordinator to provide additional support. There were photos on the walls of people participating in activities, which included art, gardening, indoor bowls, and singing and keep fit. The external activity provider visited monthly. For example the salvation army provided sing –along sessions. The activities co-ordinator said that from the spring, they would be working with interested people on one particular area of the garden. They aimed to enter it into the Local Gardens in Bloom competition.

All the relatives spoken with were aware of the available activities. One relative said their family member was really keen on the gardening, 'X loves going out and helping with tidying up and planting.' X is able to choose whether or not they wanted to participate in any activity 'they couldn't make them if they didn't want to do something.' Another relative said that they knew that activities were available but her family would not be able or willing to join in with them. One person said they liked painting.

The environment was adapted to help people living with dementia. It was homely with meaningful items on display. For example, pictures and objects on the corridor walls and lounges provided interest and stimulation. On the ground floor a sewing machine was used as a prompt to provide opportunities for reminiscence as did other objects from the fifties and sixties.

There was a system in place to address any complaints. This included a complaints procedure which was available to people who used the service. No-one we spoke with

Good

Is the service responsive?

raised any concerns. They said they would feel comfortable speaking with the manager or staff if they needed to. One person said: "I know how to complain but I have no complaint"

Another person said if they were unhappy with anything: "I would talk to any of the staff around here, they would help." Relatives told us they would not worry about raising any concern and felt that if they did, it would be responded to appropriately. One relative said that if they had a problem, concern or complaint they felt they could always see the manager and would not feel anxious about doing so. Another relative said they were told by the registered manager 'don't let worry build up. If you're worried about anything come and talk to me or a nurse, don't go home with it.'

Complaints received during 2014 had been responded to in line with the provider's procedure. The complainants were sent a letter assuring them that the issues they raised would be investigated and expressing concern about their dissatisfaction.

Good

Is the service well-led?

Our findings

Staff and health and social care professionals we spoke with told us the staff and the management were consistent in their approach to people's care. One health professional told us "I have no concerns about the home, the manager is approachable. They have good staff and care is positive. It is a dementia friendly home".

People and their relatives were asked for their views about the service they received. The registered manager told us the home used annual surveys and regular meetings to gain people's views. We sampled the returned questionnaires from the surveys carried out in September 2013 and in March 2014. They showed that people were happy with the service provided. They said they had analysed the returned questionnaires and made changes at the home if necessary.

One person commented positively about the improvements in the garden.

The registered manager told us that a people and relatives feedback survey had been sent out during February 2015. Some responses had been received but had not been analysed at the time of our inspection. We reviewed the responses received to date and comments included "I am well pleased with the care X receives, the liaison as necessary and the ambiance at Robinson House", "I am so grateful to all those looking after X because without them I could not have managed on my own" and "The staff are excellent. They truly care about everyone, including the relatives". Not all of the comments we saw were as positive. For example, people had also written "The only shortcoming is when you phone reception, which is very friendly and welcoming, but the phone is not answered on the unit", "There aren't enough activities" and "I am well informed of various decisions, but at times I do have to ask". The registered manager told us they would develop and action plan to address these comments.

Staff attended staff meetings to keep up to date with changes within the service. The last minutes seen were for a meeting in March 2015 with the night staff. Staff told us that the meeting enabled them to keep up to date with changes to people's needs as well as the policies and procedures. They told us they attended regular meetings where they could voice their opinions. One staff member told us "these meetings are really helpful. It is a good way of saying what will help to improve the home". Comments from staff included: "Brunel care's ethos is good and they are very supportive. We get lots of good training".

The management team has provided clear leadership to the team which staff valued.

The staff said they enjoyed working at the home. They also said they could take issues to the registered manager, who they felt were very approachable. One staff member told us, "There have been lots of changes for the better. It's like an extended family here now."

Where people needed additional support prompt referrals had been made to the GP or other healthcare professionals. This included referrals to their GP, district nurse team and dieticians. Health professionals told us, "Staff are very good. They have a good staff group who meet people's needs and communicate well." They said they felt the management team were very approachable.

Staff were clear about their roles and responsibilities. Staff had access to policies and procedures, as well as a staff handbook, to inform and guide them in in their roles. These included policies on moving and handling and equality and diversity. Staff training and development needs had been assessed to enable the manager to arrange future training sessions.

Monthly quality audits had been complete to improve the service. This included areas such as infection control, medication practices, health and safety. Action points were clearly identified and there was evidence in follow up audits that these had been followed up. For example care plan audits, pressure area care audit. There were detailed information, grade of pressure sore, dressing being used and interaction with Tissue Viability Nurse (TVN).

Systems were in place to make sure that the registered manager and staff learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risks to people and helped the service to continually improve. For example falls record enabled the home to look for trends to reduce the risk to the individual and improve their care.

Staff told us that they received regular supervision and on-going support from the registered manager, or line

Good

Is the service well-led?

manager. They told us the manager was approachable and they felt confident they would always be listened to. Staff told us morale was good and they felt valued. One new staff member told us "I have been really well supported so far".

The registered manager told us that their vision was to make the most of the people's lives who live and work at Robinson House. This was achieved by support and development. They aim to build a team to deliver positive and effective care to the people who live in Robinson house. Their values were that of honesty, transparency with an open door policy so people were able to express their views to improve the service. The staff were aware of this vision. For example, one staff member told us "we have good relationship with our residents and their families and staff work as a team. We have a person centred approach and our home is not institutionalised. Our relatives and visitors come and go as they like". Another staff member said "we are building a home where we encourage our residents to be as independent at they can. We provide them with person centred care, treat them well and provide them with choices".

The registered manager confirmed that they had the skills and knowledge to manager the service. They told us that they had achieved the level 5 diplomas in management and leadership, dementia care matters and also a dementia care trainer for the home. Other courses completed included the registered manager's award (RMA) and dementia care in end of life. This meant that the registered manager had the necessary qualifications, skills and experience to manage the service.

We saw a file of thanks and compliments about Robinson House one letter described the service as a "brilliant service."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with management of medicines. Regulation 12 (f) (g) because of inadequate training