Lanemile Limited

Tall Trees

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 6th October 2016 and was unannounced.

Tall Trees provides accommodation and personal care for up to 48 older people who may also have dementia and nursing needs. Care is provided on two floors. At the time of our visit there were 41 people living in the service.

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

People were safe because staff supported them to understand how to keep safe and staff knew how to manage risk effectively. There were appropriate arrangements in place for medication to be stored and administered safely, and there were sufficient numbers of care staff with the correct skills and knowledge to safely meet people's needs.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and are required to report on what we find. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The DoLS are a code of practice to supplement the main MCA code of practice. Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals. This ensured that the decision was taken in accordance with the Mental Capacity Act.

People's care plans were individual and contained information about people's needs, likes and dislikes and their ability to make decisions.

People had access to healthcare professionals. A choice of food and drink was available that reflected their nutritional needs, and took into account their personal lifestyle preferences or health care needs.

Staff had good relationships with people who used the service and were attentive to their needs. People's privacy and dignity was respected at all times.

People were encouraged to follow their interests and hobbies. They were supported to keep in contact with their family and friends.

There was a strong management team who encouraged an open culture and who led by example.

The management team had systems in place to monitor the quality and safety of the service provided, and to drive improvements where this was required.

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.

The provider had systems in place to manage risks. Staff understood how to recognise, respond and report abuse or any concerns they had about safe care practices.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Staff were only employed after all essential pre-employment checks had been satisfactorily completed.

The service had robust infection control systems in place.

Is the service effective?

Good

The service was effective

The manager had carried out the necessary Mental Capacity Assessments. (MCA)

People were supported to have a balanced diet and to make choices about the food and drink on offer.

Staff knew people well and understood how to provide appropriate support to meet their health and nutritional needs.

People had access to healthcare professionals when they required them

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy and dignity was maintained.

Staff were kind and considerate in the way that they provided care and support.

Is the service responsive?

Good

The service was responsive.

People and their relatives had continued input into the care they received.

Information recorded within people's care plans was consistent and provided sufficient detailed information to enable staff to deliver care that met people's individual needs.

People who lived at the home and their relatives were confident to raise concerns if they arose and that they would be dealt with appropriately.

Is the service well-led?

Good

The service was well-led

There was a positive, open and transparent culture where the needs of the people were at the centre of how the service was run.

The management team supported staff at all times and led by example.

Staff received the support and guidance they needed to provide good care and support.

The service had an effective quality assurance system. The quality of the service provided was regularly monitored and people were asked for their views.

Tall Trees

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.

At the last inspection in 2015 we had concerns around the level of suitable qualified and competent staff being available, person centred care and meeting the nutritional needs of people and asked the provider to make improvements.

The provider had sent us a detailed action plan. Therefore part of this inspection was to ensure that they had carried out the necessary actions detailed in the plan. We were satisfied that they had made improvements and were now meeting these regulations.

This inspection took place 6 October 2016. It was unannounced and was carried out by two inspectors a Specialist Adviser and one Expert-by-Experience. On this occasion our specialist was a nurse with experience with working with older people, including those who have lived in residential care. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service, and their expertise was in the care of older people.

Before our 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 also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We observed the interaction between people who used the service and the staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service to us.

During the inspection we spoke with seven people who used the service, the registered manager and deputy

manager and six care staff, two nurses and two chefs. We also spoke with four relatives that were visiting at the time of our inspection. We made phone calls after the inspection to healthcare professionals to obtain their views about the service.

We reviewed fifteen people's care records, staff recruitment records, medication charts, staffing rotas and records which related to how the service monitored staffing levels and the quality of the service. We also looked at information which related to the management of the service such as health and safety records, quality monitoring audits and records of complaints.

Good

Is the service safe?

Our findings

At the last inspection in we identified a breach of Regulation as there was not sufficient numbers of suitably qualified competent, skilled and experienced staff to meet people's needs. At this inspection we found that changes had been made and there were sufficient numbers of suitably qualified staff available to meet people's needs.

However, people's comments varied regarding the staffing levels in the service. One person said, "There are usually enough staff sometimes you have to wait." Another person told us, "I ring the call bell if I need them and they come quite quickly, I am not kept waiting." However another person told us, "I ring the bell and am kept waiting for up to 20 minutes there is not enough staff." Staff told us, there is usually enough staff weekends can be a problem if someone goes off sick, in the week the management will step in and help." Agency staff were used on occasion to support people who required 1:1 support for a change in need. For example, a deterioration in their health. The manager told us they used the same agency and asked for the same staff to try and provide continuity in peoples care.

During the inspection we observed staff responding to call bells promptly people were not kept waiting. Staff were deployed effectively to keep people safe a staff member was always in the communal areas and therefore on hand to ensure the safety and wellbeing of everyone. People's relatives told us they thought their family member was safe living in the service. One relative told us, "[Name of relative] had someone who kept wandering into her room so this person now has 1:1 hours so staff keep an eye on their whereabouts and [relative] has a pressure mat on her floor so if someone enters it will sound an alarm."

The deputy manager explained how they assessed staffing levels and skill mix to make sure there was sufficient staff to provide care and support to a high standard and that on occasion's staff may have to be flexible and work on a different floor to support people if there were staff shortages due to sickness or annual leave or training. Staffing rotas showed the home had sufficient skilled staff to meet people's needs and our observations confirmed this.

There were policies and procedures regarding the safeguarding of people. Staff had received training, and understood their roles and responsibilities to recognise respond to and report any incidents or allegations of abuse, harm or neglect. It was evident from our discussions with them that most staff had a good awareness of what constituted abuse or poor practice, and knew the processes for making safeguarding referrals to the local authority. Our records showed that the manager was aware of their responsibilities with regards to keeping people safe, and reported concerns appropriately. There were key codes on external doors to prevent people from leaving the premises without staff being aware.

People's risks were well managed. Care records showed that each person had been assessed for risks before they moved into the home and again on admission. Any potential risks to people's safety were identified. Assessments included the risk of falls, skin damage, and nutritional risks, including the risk of choking and moving and handling. Where risks were identified there were some measures in place to reduce them where possible. All risk assessments had been reviewed on a regular basis and any changes noted.

The service used assessment tools to identify people who may be at risk these included, water low scoring system to assess the risk of pressure sores, Falls Risk Assessment Scale (FRASE) and the Malnutrition Screen Tool (MUST). We also saw completed assessments for oral health, continence assessments along with the Abbey Pain Scale for dementia care. These were updated regularly and a traffic light system was used to highlight the individual's risk.

We saw that there were processes in place to manage risks related to the operation of the service. These covered all areas of the management of the property, such as gas safety checks and the servicing of lifts and equipment such as hoists used at the home. There were appropriate plans in place in case of emergencies, for example evacuation procedures in the event of a fire. The service employed a maintenance man to deal with any general repairs.

People were satisfied with the way their medicines were managed. People were protected by safe systems for the storage, administration and recording of medicines. Medicines were kept securely and at the right temperatures so that they did not spoil. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled staff to know what medicines were on the premises. We saw staff administer people's medicines safely, by checking each person's medicines with their individual records before administering them, to confirm the right people got the right medicines. Although all staff was trained to administer medication it was Nursing staff who were responsible for ensuring people received their medication. Regular competency assessments were carried out to ensure the nursing staff were following best practice. We noticed that the nurse on occasion when administering medication was disturbed by other staff asking questions. We discussed this with the registered manager as this interruption could lead to errors and we were told they had a tabard to wear to inform relatives and staff that they should not be disturbed whilst administering people's medicines but on this occasion had not worn it. The manager said she would talk to the nursing staff about the importance of wearing the tabard in future.

Staff recruitment files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS). This scheme enables the provider to check that candidates are suitable for employment. People could be assured that their needs were being met by staff that had been assessed as safe and competent, with the necessary skills for the job role they had been employed for.

The service had robust infection control systems in place, we observed throughout our visit staff maintaining high levels of cleanliness and infection control. Staff were trained and updated in food hygiene and infection control. Cleaning materials were organised and safely stored. Cleaning rotas and audits were available and updated. Communal areas were clean and inviting with no offensive odours, the kitchen in which the food was prepared was organised and clean and staff could not enter without wearing protective clothing. Staff had access to protective clothing for example gloves and aprons and there were facilities to dispose of these safely.

Good

Is the service effective?

Our findings

At the last inspection we found a breach in regulation because the provider had failed to ensure that they were meeting people's nutritional and hydration needs. At this inspection we found that changes had been made and people's nutritional and hydration needs were being met.

We looked at people's weight and nutritional records. People had detailed nutritional risk assessments in place and were weighed on a regular basis. People identified as losing weight were referred to the GP and dietician for advice. The GP set all fluid intake targets and staff were clear that any people who did not meet the fluid intake target were re-referred to the GP. Some people because of concerns around their weight were on high calorie fortified drinks and snacks. People commented positively on the smoothies and flavoured cream shots they were offered as a way of them receiving the necessary calories. Records confirmed people were being given these when required. Where people had lost weight or had another indicator that may have put them at risk, such as loss of appetite they were weighed weekly. The electronic records we looked at had no gaps in people's weight records.

The chef attended a 'weight loss' meeting on a monthly basis, along with the registered manager, deputy manager and nursing staff to discuss people who were at risk and people who had lost weight. We saw the minutes of the meetings which were detailed giving actions for people who had lost weight or put on too much weight. For example, offering healthy snacks. The chef informed us that since the introduction of 'cream shots' which were served in shot glasses and therefore looked appealing to drink, people's weight had increased. They were researching different flavours to use in the 'cream shots' and smoothies in order to keep people interested and had recently found a Christmas pudding smoothie recipe which they were going to try out.

We saw evidence throughout the day of inspection of people being offered drinks and snacks and for people who were able to help themselves snacks of chocolate, crisps, fruit or biscuits were in the communal areas. These included a variety of gluten free ones for people who had to follow this diet. People were complimentary about the food comments included, "The food is always lovely, yes, I have a choice and they make something else if you don't want what is on the menu." And "I like the food there is always plenty to eat."

We observed the lunchtime meal. The tables were nicely set with table cloths and napkins. Tables were placed at various heights with the aid of height adjusters depending on people's needs they were asked where they wanted to sit. The meal was attractively presented and looked nutritious. Food that had been pureed for people still looked nicely presented, each individual food had been pureed separately and people were asked if they wanted gravy put on top. People had a choice of meals taken to them on 'show plates' in order for them to make a visual choice. This is particular important for people living with dementia as they can be confused about meal choices and would not necessarily remember what they had chosen the day before. A choice of drinks was offered and again each drink was taken to people for them to decide what they would like. People who were cared for in bed or who chose to eat in their rooms also had the 'show' plates and drinks taken to them.

People who needed support and encouragement to eat were supported by a staff member who sat alongside the individual and the assistance given was appropriately paced.

The meal was served by a member of kitchen staff who was responsible for all food provision and preparation. This meant it freed up staff to be available to support people with eating their meal rather than having to serve the food as well. The chef was knowledgeable about peoples nutritional and hydration needs and was able to talk to us in-depth about people's varied dietary needs.

Afternoon tea when served included a variety of cakes, fruit, and sausage rolls these had all been freshly baked and looked appetising and appealing. People looked like they were enjoying the snacks on offer and were encouraged to make a choice about what they would like to eat.

Staff had the necessary skills to meet people's needs. They communicated and interacted well with the people who used the service. Staff were appropriately trained and supported for the roles they were employed to perform. All staff we spoke with told us they had been supported with training relevant to their role and how this enabled them to understand and meet people's needs. For example, they were able to demonstrate to us through discussion and our observations throughout the day of inspection; how they supported people in the areas they had completed training in such as moving and handling, dementia and falls prevention. We observed someone being hoisted from a chair to a wheelchair this was done competently by two staff that treated the person with dignity and respect talking to them through each process.

All new staff were inducted into the role and given the help and support that they needed. This included completion of shadow shifts which entailed working alongside a senior or experienced staff member. Newly appointed staff confirmed that they were in the process of completing the care certificate which is a nationally recognised induction for staff new to the care sector. One member of staff told us, "You can ask for more shadow shifts before providing care on your own if you feel you need them."

Staff had attended face to face dementia training and were able to talk to us about the changing needs of people living with dementia.

Staff were supported with regular supervision which included guidance on their development needs. Records we looked at confirmed this. Staff also had observations of their practice and were guided in how to improve their practice in areas if need be. One member of staff told us, "We all have regular supervision's we can discuss any problems or issues and talk about training." Staff also attended staff meetings where they could discuss both matters that affected them and the care management and welfare of the people who lived in the service.

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. Care records confirmed that the management team carried out MCA assessments to consider people's ability to make day-to-day decisions. The registered manager demonstrated that they understood the processes to be followed to assess people's capacity.

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 checked whether the service was working within the

principles of the MCA and found that they were. We noted that, where people did not have capacity, applications had been submitted to the local authority. Where people did have capacity we saw that staff supported them to make day to day decisions, and sought consent before providing care.

People's day to day health needs were being met and they had access to healthcare professionals according to their specific needs. People old us that staff took appropriate action to contact health care professionals when it was needed. One relative told us, "When [relative] is not well they always call the doctor they keep me informed." Another relative told us, "They always notice if [relative] is unwell and call the doctor it stops things getting worse."

We saw the service also had contact and support from other healthcare professionals in maintaining people's healthcare. These included speech and language therapists, the chiropodist, dietician and physiotherapist. A health care professional told us the staff contacted them at an early stage which showed good monitoring and that staff listened and followed advice given to support people's health and well-being.

Good

Is the service caring?

Our findings

One relative told us that staff were, "Calm and considerate nothing is too much trouble for them they are all lovely." Another person told us that carers are, "Understanding and patient, they do what they can for you."

Throughout the inspection we saw that staff treated people with kindness and compassion. People had good relationships with staff and communication was friendly and warm. Staff offered comfort and reassurance when needed. Staff held people's hands when talking with them. We observed one person getting upset the carer calmly went to them and sat with them talking to them in a quite reassuring voice until the person calmed down. One relative told us, "The staff are very good at using distraction when needed." A member of staff said some people when unsettled become more relaxed when you sing their favourite songs with them.

A staff member told us that many of the staff had been working at the service for some time and said they knew people well. People told us that they were offered choices such as, what they ate, what time they liked to get up in the morning and how often they had a bath. One person said, "I have breakfast in bed sometimes depending on how I am feeling on the day."

Staff were respectful in their approach to people in terms of how they addressed people and in how they supported them too. Everyone was appropriately dressed with clean laundered clothes. People had clean glasses and well-manicured clean nails. We observed one person being supported with their hearing aid staff were ensuring it was switched on and correctly fitted. One person told us, "They are good at treating you with respect they always keep you covered, when they are helping you with the door closed and curtains drawn." One relative told us, "They always make sure [relative] has hand cream on and perfume these things are important to [relative]."

We observed staff knocking on bathroom doors before entering and when people's bedroom doors were shut staff knocked and waited for a reply before entering.

People who had different cultures or religions had their needs met. For example, one person who chose to eat a different diet for cultural reasons had a birthday meal of all of their favourite food stuffs. Their family visited on their birthday and a birthday meal had been organised which included foods relevant to their culture. The chef was really enthusiastic in talking to us and telling us about the different foods they had prepared. This meant that people had their different religions and cultures respected. People told us they were supported by religious service's held in the home. People also had access to individual religious support should they require this.

We looked at fifteen people's care plans and saw that they contained some comprehensive information about people's likes and their personal history; this gave staff the tools to open up a discussion with people and evoke memories.

Concerns were raised in the last inspection around staff having enough knowledge around end of life care

therefore the provider had forged strong links with a local hospice and additional training had been given to staff around palliative care. Staff were therefore able to discuss confidently the arrangements for people receiving end of life care.

Care plans described how people wanted to be supported during the end stages of their life and their wishes were recorded. One relative told us, "We have had a discussion about [relative] end of life plan it is all down in [relative] care plan and I have every confidence they will carry out our wishes." Where people had made a decision about resuscitation a completed 'Do Not Attempt Resuscitation' (DNAR) directive was in place. Where possible people had been involved in their care plan and when this had not been possible a family member or advocate had been consulted about the care their relative needed. An advocate is someone who supports people to speak up about what they want, working in partnership with them to ensure they can access their rights and the services they need.

One relative told us, "I am kept fully informed about all aspects of [relative] care they are very good in letting me know what is going on and asking me for my thoughts." This assured us that people had been involved in making decisions and planning their care.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. People and their relatives were involved in planning and reviewing their care needs. People were supported as individuals, including looking after their social interests and well- being.

Before people came to live at the service their needs were assessed to see if they could be met by the service and care plans developed. Relatives we spoke with said they came to look around the service and meet the staff before making a decision about their relative coming to live there. The deputy manager told us they assessed people's needs before they came to live at the service and invited people to come and look around. From the assessment care plans were developed the care plans were individual to people's needs and described how to best support them to maintain their safety and independence. The care plans were regularly reviewed and updated if people's needs changed. This told us that the care provided by staff was up to date and relevant to people's needs.

The service was responsive to people's needs for care, treatment and support. The registered manager was very prompt at getting support from health professionals when people required it. People's rooms were fitted out with equipment to suit their needs and to enable them to maintain their independence.

There was a range of activities available in the home and the home employed an activities co-ordinator although on the day of inspection they were on holiday therefore activities were scaled down. We did observe people making collages and interacting with staff when it was finished they showed us the finished product and had clearly enjoyed the activity. Another person was having a hand massage and someone else was singing with a member of staff. People were encouraged to make choices about where they wanted to be during the day and what activities they wanted to participate in. One staff member told us, "The activities co-ordinator spends time with people finding out what they like to do and asks relatives about peoples hobbies and interest." We saw a timetable displayed of activities offered which included arts and crafts, reminiscence or singing sessions, and bingo as well as one to one activities such as hand massage. People went on trips out to the coast or to a garden centre. People told us, "There is always something going on but we don't have to join in if we don't want to." And "We go to coffee mornings at the local church."

The service employed volunteers who were supported by the activity co-ordinator and they carried out 1:1 activities with people such as painting their nails or hand massage. One person showed us their nails which had been painted in their favourite colour green.

The environment was dementia friendly and people could wander freely without restrictions. There were different areas to sit and including seating in the corridors with small tables. Sensory items were placed around the home and we observed people using them. One person was busy hanging washing out on a line that was hung in the corridor and during the day collected the items and then hung some different ones out. This meant people were occupied with meaningful activities.

There was a conservatory that had been made into a garden room with a tray with real soil with forks and

spades and sensory objects such as a water fountain with running water. This area was for people to sit and relax in as well as to use the soil for sensory purposes. This room felt quite cold and we mentioned this to the manager who told us it had only just been finished and they were aware it required some additional heating. Outside in the garden was a small car and staff told us that on occasion one person liked to sit in the car with staff to alleviate their anxiety when anxious and upset.

The service had policies and procedures in place for receiving and dealing with complaints and concerns received. We noted that complaints were logged and there was a clear process for acting on complaints and a record of what had been learn as a result of the complaint. This reduced the likelihood of repeated concerns being raised. People's relatives told us they had no complaints but if they did they would speak to the manager. We saw a number of compliment cards displayed in reception which were from family members thanking staff for the care and support they had shown to their relative.

Good

Is the service well-led?

Our findings

The service had a registered manager who was supported by a deputy manager and they were both clearly visible within the service. The management team had a very good knowledge of all the people living there and their relatives. The deputy manager also worked shifts on the floor and supported the staff. People, their relatives and staff were very complimentary of the management. One person told us, "The managers are always around to talk to they are still here late at night sometimes, they definitely do not work 9-5."

Whilst talking to some staff it became apparent that they did not have a lot of respect for the registered manager. We discussed our findings with the management team who told us they were aware of this amongst some staff and that it was being dealt with in supervision. They felt the reason was because some changes had been made in that staff had been asked to be more flexible and work between both floors of the service when required. These particular staff members saw these changes in a negative light and had therefore shown lack of respect and low staff morale. The registered manager told us these changes were necessary to ensure that people's needs were being met and to maintain a high standard of care and support. Other staff we spoke with understood the reasons for the changes, "One person said, "We are here to look after people it shouldn't matter who you work with or what floor you work on, the people come first."

People were involved in developing the service and were provided with the opportunity to share their views. This included satisfaction questionnaires and meetings. The summary of recent satisfaction questionnaires included an action plan which showed improvements were made following people's comments, such as in activities that were offered Surveys were also undertaken with people's relatives, on the telephone and in writing. One person's relative told us, "They have relative meetings last time I was the only one there so we reviewed my [relative] care plan." We spoke to visiting relatives during the inspection and some people informed us they were not aware of the relative meetings even though the dates and times were clearly displayed on the notice board. We discussed this with the manager who said they would print off some flyers to place in the reception area alongside the visitors signing in book therefore people would be informed of the date of the relatives meeting.

The registered manager also had an open door policy and held weekly surgeries for staff or relatives so they could drop in and discuss any issues they were concerned about. These were held on a weekly basis and relative and resident meetings were held every couple of months. We observed the registered manager walking around the service and talking to people and their relatives. The deputy manager supported staff in caring for people and we observed them helping staff with 1:1 support around mealtimes. Staff told us, "[deputy manager] is always helping us and giving advice we don't see much of the [manager] but she is in the office."

The service had a quality assurance system in place audits were carried out on a monthly basis by the regional manager and an action plan was produced with objectives and outcomes that had to be completed within an agreed timescale.

The registered manager provided us with clear audits of falls, incidents and accidents showing clearly what action had been taken as a result and what future learning had been adopted to try and reduce the likelihood of it happening again. For example, someone who had had a fall their risk assessment had been reviewed and updated accordingly.

The registered manager told us they were supported by a 'mentor' who was another registered manager employed by the company in a home nearby; they were available to offer support and to talk through and issues or problems that may arise.