Vallance Organisation Limited

Vallance Residential Care Home

Inspection report

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Date of inspection visit:
16 December 2015

Date of publication:
31 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Vallance Residential care Home on the 14 and 16 December 2015. Vallance Residential Care Home is a care home providing care and support for up to 19 people. On both days of the inspection 16 people were living at the home. The age range of people living at the home varied between 60 – 100 years old. Nearly everyone residing at the home was living with dementia or mental health needs. Care and support was also provided to people with diabetes, sensory impairment and long term healthcare needs.

Accommodation was provided over two floors with stairs connecting all floors and a stair lift in situ. The property is two detached Victorian buildings which are conjoined. A garden was available at the back of the home for people to access. The home is centrally located in Hove with good public transport links to the city centre and sea front.

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

People spoke highly of the deputy manager and commented they would recommend the home to others. One person told us, "I would recommend it as it had been to me yes." Another person told us, "It's very nice here, they treat you well."

One concern was that a systematic approach to determining staffing levels was not robustly in place. The provider was unable to demonstrate how only one member of staff at night was sufficient to meet the needs of 16 people, most of whom were living with dementia. People also raised concerns around staffing at night. One person told us, "I'd have thought there should be two carers really." Another person told us, "I tend not to ring my bell at night time as there's only one on and you can see they look run ragged so I try and manage." Consideration had not been given to what would happen if the home needed to be evacuated at night. We have identified this as an area of practice that is of significant concern.

Incidents and accidents were not monitored for any emerging trends, themes or patterns. The management of falls required improvement. People's call bells were not consistently made available to them when sitting in their chairs. We have identified this as an area of practice that requires improvements.

Robust systems were not in place to analyse, monitor or review the quality of the service provided. The provider was not completing formal audits and there were no formal mechanisms to assess the standards of care. We have therefore identified this as an area of practice that requires improvement.

Where people had bed rails in place, documentation failed to identify if the person had consented to the bed rails or not. Where people lacked capacity under the Mental Capacity Act (MCA) 2005, the provider was

unable to demonstrate how care was delivered in line with legal requirements. We have identified this as an area of practice that needs improvement.

Improvements were needed around the opportunities for people to engage with meaningful activities. Activities were provided which included bingo, quizzes, exercises and arts and crafts; however, activities centred on the person and meaningful to them were not consistently in place. People also had mixed opinions about the opportunity for social engagement. One person told us, "I enjoy singing, there's not a lot to do I thought there'd be more." Where people were at risk of social isolation, this had not been addressed. We have made a recommendation for improvement in this area.

The principles of person centred care and good dementia care were not consistently upheld. Not all care workers had received dementia training or training specific to the needs of people they supported. We observed interactions between people and staff which did not uphold the principles of person centred care or good dementia care. Where people had lost weight, documentation was not always in place to reflect what action had been taken. We have identified this as an area of practice that needs improvement.

Care workers demonstrated a fondness for the people they supported. From observing staff interacting with people, it was clear they had spent time with people, getting to know them, gaining an understanding of their personal history and building friendships with them. People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. One person told us, "They've started doing some fancy dishes and it's nice to have a change."

Each person had a care plan that outlined their needs and the support required to meet those needs. Care plans were personalised to the individual and included information on their life history. People were called by their preferred name and they were spoken with and supported in a sensitive, respectful and caring manner. People were seen laughing and smiling with care workers. Care workers understood the importance of monitoring people's health and well-being on a daily basis.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before care workers began work.

There was a friendly, relaxed atmosphere at the home. The provider and registered manager were dedicated to a running a care home that focused on family values. The registered manager told us, "This is a family run care home." Vallance Residential Care Home is one of the oldest running residential care homes in Brighton and Hove. The home opened it 1980 and the provider and registered manager told us, "We are incredibly proud of the home and the dedicated staff team."

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Vallance Residential Care Home was not consistently safe. Staffing levels were not based on the individual needs of people and robust systems were not in place for reviewing and assessing staffing levels. Falls risk assessments were not reviewed in light of any falls and call bells were not consistently made available to people.

People received their medicines on time; however, the provider was unable to demonstrate the actual quantity of medicines they held.

Care workers had a clear understanding of the procedures in place to safeguard people from abuse. Recruitment systems were in place to ensure staff were suitable to work with people. Risks associated with the environment and premises were maintained.

Is the service effective?

Requires Improvement

Vallance Residential Care Home was not consistently effective. Not all care workers had received dementia training or specialist training to meet the needs of people. Training was not always embedded into practice.

For people with bed rails in situ, documentation did not record if least restrictive options had been considered or if the person consented to the bed rails.

People spoke highly of the food provided; however, documentation did not always reflect what action had been taken when people had lost weight.
People's health was monitored and staff responded when health needs changed.
changed.

Is the service caring?

Good

Vallance Residential Care Home was caring. There was a welcoming, friendly atmosphere in the home and people felt care workers were kind and caring.

People responded to staff with smiles. People were supported to maintain their physical appearance and promote their identity. People's privacy and dignity was respected and people were encouraged to make their bedrooms their own.

Mechanisms were in place to involve people in the running of the home.

Is the service responsive?

Requires Improvement

Vallance Residential Care Home was not consistently responsive. The opportunity for meaningful activities was limited and the risk of social isolation had not been addressed.

Person centred practice was not consistently embedded into practice.

Care plans were detailed and contained clear information on how to provide care to the individual. There was a complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

Is the service well-led?

Requires Improvement

Vallance Residential Care Home was not consistently well-led. There was not a robust system in place for monitoring, evaluating and assessing the quality of care.

People spoke highly of the deputy manager and commented they would recommend the home to other people. The provider and registered manager both commented on how Vallance Residential Care Home was a family run care home with family values at the forefront of care delivery.

Vallance Residential 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 was an unannounced inspection on 14 and 16 December 2015. It was undertaken by two 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 service. During the inspection, we spoke with nine people who lived at the home, one visiting relative, six care workers, the registered manager, director and deputy manager via telephone after the inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this was because the inspection was carried out at short notice. A PIR 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. Vallance Residential Care Home was last inspected in November 2014, where we had no concerns.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounges and the dining room. We spent time sitting with people in the communal lounges, talking and interacting. We also spent time observing the delivery of care and support in the communal areas.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Vallance Residential Care Home. This is when we looked at their care documentation in depth and obtained their views on how they found living at Vallance Residential Care Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Vallance Residential Care Home. People confirmed they felt free from harm and enjoyed the freedom the home offered. One person told us, "I love the freedom here." Another person told us, "Funnily enough, I feel safer here as it's run more like a business. Where I was before, it was more like a family but I feel more secure her for that reason." Despite people's high praise, we found areas of practice which were not consistently safe.

Robust systematic approaches were not in place for determining, assessing and reviewing staffing levels. Staffing levels consisted of the deputy manager, a senior care worker, a chef who is also an experienced carer, cleaner and another care worker. An activities co-ordinator worked three afternoons a week. At weekends, until 14.00 two care workers and a cleaner or senior care worker would be working. After 13.00pm there would only be two care workers. The night time shift consisted of one care worker. We queried with the management team how it was reviewed that at night time only one member of staff was sufficient to meet the needs of 16 people, nearly of all whom were living with dementia or experienced a mental health need. We also queried how it was assessed that two care workers at weekends was sufficient, as between those two care workers, they had to prepare suppertime, administer medicines, meet continence needs and provide stimulation. A member of the management team told us, "A dependency tool is not in place but when needed we have increased staffing levels." The registered manager told us, "A couple of years ago, I felt we needed to increase staffing levels and that's why we now have a senior care worker and a separate cook." Subsequent to the inspection, the deputy manager sent us a level of care document which considered the level of care for each person on a day to day basis. The provider clarified that this was used to determine staffing levels. They told us it was reviewed on a weekly basis and was used to record items such as the administration of medication, the progress of dementia in people, details concerning two hourly checks and hospital admissions. However, it was not clear how this then helped determine staffing levels and assessed that only one care worker at night was safe and only two care workers after 13.00pm was sufficient. The registered manager and member of the management team were also unaware this documentation was in place.

Care workers spoke positively of the staffing levels and raised no concerns. One care worker told us, "Everything gets done." Another care worker told us, "Staffing not a problem, we work as a team." People also thought that no one had come to any harm as a result of insufficient staff, however, people made reference to the fact that were was only one member of staff on duty at night. One person told us, "I tend not to ring my bell at night time as there's only one on and you can see they look run ragged so I try and manage." Another person told us, "I had a fall once at night and broke my hip, I was seen to quickly enough but I'm not sure how long I would have been there if the carer was at the other end of the building seeing to someone else." A third person told us, "I'd have thought there should be two carers really." Other people raised concerns and queried what would happen if the care worker themselves fell ill or fell over. The provider told us that all night staff carried a mobile phone with them at all times during their shift. Two separate lines come into the building on all floors throughout the home. Additionally, phones were cordless and enabled staff to make telephone calls immediately they required any assistance. We were told by the provider that staff positioned themselves in the middle of the home to listen out for any person who called

for assistance or were walking around. This ran alongside their regular two hourly checks. A lone working policy was in place and we were informed that a lone working risk assessment was in place but this could not be located by the registered manager. However, all night staff attended a Maintaining Care Quality at Night course offered by the local authority in October 2015.

Each person had an individual fire evacuation plan which detailed the level of support they would require to safely evacuate the home. Due to people's reduced mobility, healthcare needs or level of dementia, the fire evacuation plan identified that people required support of one care worker to safely evacuate the home. A fire risk assessment dated from 2013 identified that, 'Whilst a fire safety policy incorporating contingency and emergency plans has been drawn up to assist management and staff to ensure that people in the work place know exactly what to do in the event of a fire, e.g. how the alarm is raised, how an evacuation would be carried out. This plan is to ensure that there are suitable and sufficient with correct staffing levels at all times for a full evacuation in the event of a major fire.' We asked a member of the management team if they had completed a fire evacuation at night. They commented, "We have recently started doing them during the day but not at night." During discussions with the registered manager we queried how they had assessed that one member of staff at night was safe. They commented, "I only live over the road and can be contacted anytime to come and assist." We therefore questioned if they had considered what would happen in the event of something happening to the care worker and being unable to contact them. The registered manager told us, "I can see your logic, maybe we do need to consider two night staff."

The provider told us all new employees were given a staff handbook that included the fire procedure in the event of a fire. They told us staff had six monthly fire training sessions with a former fire officer that included evacuation procedures to be followed. We asked care workers what they would do in the event of a fire. Care workers were not consistently sure of the actions required. One care worker, who had recently commenced employment at the home, was unaware that people had individual fire evacuation plans and training schedules confirmed they had not received fire training. The provider assured us that as part of their induction they worked alongside a team of experienced staff and were scheduled to attend fire training within their three month probationary period. They told us night staff had additional in-house training to be delivered every three months following our inspection.

Observations and documentation reflected that no serious harm had occurred to people due to insufficient staffing levels, however, incidents and accidents reflected that incidents were occurring at night time. Documentation reflected that people had fallen at night. For example, in July 2015 there had been six falls with three people falling at night. Incident and accident documentation also reflected that when people had fallen the ambulance service was called in line with advice received from the local authority; therefore leaving the care worker to manage the person involved in the incident, check on other people and liaise with the paramedics. For example, on the 25 August 2015 a person was found on the floor between the bed and the wall, the paramedics were called to help get the person up. One person told us, "I had a fall and it was two hours before anyone came and another time it seemed like four hours. I tried banging on the floor but they can't hear you downstairs." Documentation (noted in the accident book) confirmed this person was found on the floor on the 8 August 2015 at 23.30pm. Hourly record checks noted they were last checked upon at 22.00pm, therefore they could have been on the floor for an hour and a half. The incident and accident documentation omitted this information and failed to record when the person was lasted checked upon.

Due to the concerns with insufficient staffing levels which potentially place people at risk of harm, we have identified a breach of Regulation 18 of the Health and Social Care Act2008 (Regulated Activities) Regulations 2014.

Older people may be at heightened risk of falls. Guidance produced by Age UK, identified that falls could destroy confidence, increase isolation and reduce independence. Falls risk assessments were in place which considered the hazard (falling), who might be harmed, what was already being done and what further action was required. Documentation also confirmed people had been referred to the falls prevention team. For example, one fall risk assessment identified that one person could walk around without their mobility aid (zimmer frame) and grab onto furniture instead. To mitigate the risk of falling, the risk assessment identified for staff to remind the person of the importance of walking with their mobility aid but not to make them feel their independence was being compromised. Following any fall, an incident/accident form was completed which identified what remedial action was taken. Documentation confirmed that one person had suffered quite a few falls. For example, one person had experienced falls in July and August 2015. The remedial action for the falls included, 'Remind (person) to always ring the bell.' Their falls risk assessment stated that it had been reviewed monthly. However, there was no documentation to consider the effectiveness of the remedial action of reminding them to use the call bell or if they needed consideration of other measures to keep the person safe, for example, by use of a falls sensor mat.

Throughout the inspection, with permission, we visited people's bedrooms and spoke to people in their bedroom. Whilst talking to people in their bedroom, we noticed that their call bells were wrapped around their bed and therefore not accessible to them while they were sitting in their chair. For example, one person's chair was the other side of the room and their call bell was wrapped around the bed. They told us that it was usual for the call bell to be wrapped around the bed and not next to them. They also added that if they fell near their chair they were unable to summon help. The provider told us the majority of bedrooms had more than one call bell. In those rooms with more than one call bell, one was attached to the chair and one attached to the bed. To ensure consistency across the home we have therefore identified this as an area of practice that needs improvement.

People told us they received their medicines on time. One person told us, "They're juggling my drugs about a bit (recommended by Parkinson's doctor) and they do make
sure I get everything on time." Another person told us, "I have eye drops each day they put in." Training schedules confirmed care workers had received training in the safe administration of medicines. Medicines were ordered in a timely fashion from the local pharmacy and each person had an individual Medication Administration Record (MAR chart) which were well maintained and reflected that the recording of the administration of medicines was in line with best practice guidelines. A current photograph of each person was attached to the MAR to ensure there were no mistakes of identity when administering medicines.

Medicines were stored in a locked cupboard in the deputy manager's office. On a daily basis the temperature of the cupboard was checked. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. Recordings reflected the temperature had reached 25c on numerous occasions. We asked a member of the management team if the temperature had ever exceeded 25c which they confirmed it had not. Over 25c would place the medicines at risk of deterioration due to the heat. Most medicines were received from the pharmacy in a blister pack (pre-packed weekly box); however, some medicine was received in a separate box, such as anti-psychotic medicine, paracetamol and other forms of pain relief. A medicine received book was in place which was meant to document when medicines were received and the quantity, however, documentation was not consistently maintained to ensure accurate stock levels. For example, the provider had received an anti-psychotic medicine on the 23 August 2015. This medicine was not signed into the medicine received book; therefore the provider had no record of how much medicine should be in stock. On the 6 June 2015, the provider had received 124 tablets of paracetamol. This had not been signed into the medicine received book, therefore there was no accurate stock level of this person's paracetamol and how much should be in stock. The MAR chart also failed to record the quantity of medicine and how much was carried forward from

the previous month cycle. Therefore accurate stock levels were not recorded and the provider was unable to account for the quantity of medicines. We have therefore identified this as an area of practice that needs improvement.

Effective systems were used to make sure care workers were only employed if they were suitable and safe to work in a care environment. Staff recruitment records confirmed the provider had undertaken all checks, such as Disclosure and Barring Service (DBS) and obtained all relevant information. This included references, application form and offer of employment. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with people.

Care workers had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the home. They had a clear understanding of who to contact to report any safety concerns and all care workers had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting
concerns if they needed to do so. There was information displayed in the home so that people, visitors and staff would know who to contact to raise any concerns if they needed to. There were clear policies and procedures available for care workers to refer to if needed.

Vallance Residential Care Home was clean, homely and well maintained. People spoke highly of the cleanliness of the home and commented staff worked hard to keep it clean. There were effective systems in place for continually monitoring the safety of the premises. These included recorded checks in relation to the fire alarm system, hot water system and appliances. In the event of an emergency, the provider had an agreement with a local care home that people could be evacuated there for safety.

Requires Improvement

Is the service effective?

Our findings

People and relatives spoke highly of the care workers and the deputy manager. People commented they felt staff had a good awareness of their needs and were good at their job. People felt their healthcare needs were met and spoke highly of the food provided. One person told us, "I have high cholesterol which has scarred my eyes and (deputy manager) organises my eye tests." Despite people's high praise, we found elements of Vallance Residential Care Home which were not consistently effective.

Guidance produced by the Alzheimer's society describes good dementia care as, 'following the principles of person-centred care.' This approach aims to see the person with dementia as an individual, rather than focusing on their illness or on abilities they may have lost. Instead of treating the person as a collection of symptoms, person-centred care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. Person-centred care also means treating 'residents' with dementia with dignity and respect. Nearly everyone at Vallance Residential Care Home was living with dementia or living with a mental health need. The deputy manager was a member of the care home in-reach team (CHIRT). The team gave advice, training and information for care homes that provide care to older people living with dementia. The provider told us about their ethos, "Part of our ethos is to treat people with memory problems as no different to anyone else and they are all treated with the same rights of choice, dignity and respect." The training schedule confirmed that dementia awareness was not a mandatory training course and only five members of staff, including the deputy manager and senior care staff, had undertaken dementia training. The provider told us these staff worked alongside care workers and passed on their knowledge. We queried how the provider delivered effective dementia care. Subsequent to the inspection, the provider told us, "Dementia care was used as a topic for one of our recent six monthly staff supervisions and the deputy manager informed us that all care workers had been booked onto dementia training in January and February 2016."

Our observations throughout the inspection found that most interactions were positive, kind and caring, however, we observed a few interactions which did not uphold the principles of good dementia care. For example, one person was walking into the dining room with a blanket on their arm. A member of staff said to them, "Be careful, I wouldn't want you to fall." Another member of staff then proceeded to say, "You don't need the blanket, it's warm enough", and then removed the blanket from the person's arm. By removing the blanket, the care worker had taken that choice away from that person and also undermined their decision that they were cold and needed a blanket. The person's body language then changed and they appeared rather unsettled by this. The provider told us this person suffered with severe anxiety and the decision to remove the blanket was in their best interest as they had a tendency to be unstable and could possibly trip over the blanket.

We brought these concerns to the attention of the registered manager and queried how they assessed whether training was embedded into practice. The registered manager confirmed further work would be done to ensure all care workers received dementia awareness training and would review how they assessed the effectiveness of the training.

Alongside living with dementia, some people were living with specific healthcare condition's, such as Parkinson's and stoma bag. Training schedules confirmed care workers had not received specific training to understand these health conditions. One person told us, "I have a stoma and there were a few problems a few weeks ago. The deputy manager knows all about it but no one else seems to know anything else about it. The deputy manager knew what to do and massaged my stomach but surely other staff here should know what to do and (deputy manager) isn't here all the time and doesn't work at night." A risk assessment was also absent on how to effectively manage the person's stoma bag and what to do in the event of a blockage. Therefore, guidance was not available for care workers to follow if the deputy manager was not present. Another person living with Parkinson's told us, "They don't always help me as much as I need them to. I can't always do things and it can change each day, so they sometimes say, 'You did that last week' and still expect me to do it it's like they expect me to carry on as I was before. " For people living with Parkinson's, their level of ability can vary on a day to day basis. One care worker told us that there were books and leaflets available on Parkinson's. We therefore questioned how the provider assessed care workers understanding of Parkinson's, especially in the absence of formal training.

Staff had not received the appropriate training as is necessary to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Training schedules confirmed staff had received training on the MCA 2005. Care workers understood the importance of gaining consent from people and that people had the right to refuse consent.

References were made in people's care plans to people lacking capacity and for care workers to act in their best interest. For example, one person's care plan identified the person was unable to manage their medicine regime; therefore they were administering their medicine in their best interest. Another care plan reflected, '(Person) has no insight into safety and risk awareness. They lack capacity to make decisions around their care needs.' We asked a member of the management team to see copies of the mental capacity assessment which determined that people lacked capacity. A member of the management team told us, "We don't undertake mental capacity assessments in house, external professionals do them." We then asked for copies of those mental capacity assessments and best interest meeting minutes which could not be located. In the absence of their own mental capacity assessment or other professional capacity assessments, the provider was unable to demonstrate how they were acting in accordance with the requirements of the MCA 2005. For example, documentation made no reference to medication being given in the person's best interest. We have therefore identified this as an area of practice that needs improvement.

Where people had bed rails in place, a bed rails risk assessment was in place which identified the bed rails were for the person's safety. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Although the risk assessment identified that the bed rails were for the person's safety, the risk assessment failed to reflect what other least restrictive options had been considered, such as low profile bed or crash mats. Though this wasn't reflected in the risk assessment, the provider subsequently told us, 'District Nurses and the Occupational Therapists assessed this area for cot sides and they concluded that in the best interest of this service user, crash mats were not an option.' However this was not apparent through the documentation or in discussion with staff in charge on the day of the inspection.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection for people ensuring their safety and human rights are protected. On the days of the inspection, 12 people were under a DoLS. Care workers were aware of who was subject to a DoLS and what that meant for that individual. One care worker told us, "We have to read why they're on DoLS, it's all about best interests and making sure it's approved for people to be restricted."

People were complimentary about the food and drink. One person told us, "You always get plenty and the food is good, you get a choice at lunchtime but not at supper." Another person told us, "They've started doing some fancy dishes and it's nice to have a change." A third person told us, "They've gone all European with the food and it's nice."

We spent time observing the lunchtime meal whilst sitting and interacting with people. The dining tables were attractively laid with tablecloths, placemats, glasses, condiments, small Christmas decorations, and cutlery. People's meals were served politely and in a caring manner with hot and cold drinks provided. Care workers understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled care workers to monitor people's nutritional intake. People's weights were recorded monthly (if consented to by the individual). Where people had lost weight, documentation was not always in place to reflect what action had been taken. For example, one person had lost seven pounds since September 2015. Documentation also confirmed they had been refusing to eat. We asked a member of the management team what action had been taken following the weight loss. They told us, "We have referred them to the dietician and just awaiting their input." In the interim we questioned what measures they were taking as documentation failed to indicate this, for example, whether they were fortifying the person's diet or offering additional snacks. A care worker told us, "We would fortify their diet and offer alternative meals." However, documentation failed to reflect this. We have therefore identified this as an area of practice that needs improvement.

People's health and wellbeing was monitored on a day to day basis. Care workers worked in partnership with district nurses, GPs, psychiatrists and other health care
professionals. Following a visit from a healthcare professional, people's care documentation would be updated to reflect the outcome of the visit. Care workers recognised that any changes in people's health could be significant. Where changes were identified, care workers checked to see if the person was suffering from a urinary tract infection (UTI) and if so, requested antibiotics. People commented that their healthcare needs were effectively managed and met. One person told us, "It's all taken care of and even the dietician comes." Another person told us, "My bra strap had cut me a bit and they got the nurse in to treat it." A third person told us, "It seemed like everyone was here yesterday even the dentist."

Good

Is the service caring?

Our findings

People and visiting relatives were all positive about the home. People felt care workers were kind, caring and compassionate. One person told us, "I'm very happy, it's homely and they are kind." Another person told us, "It's very nice here they treat you well."

The atmosphere in the home was calm, relaxed but with a friendly and homely feel. One care worker told us, "From the start I've liked the cosiness and friendliness of the home." With Christmas approaching, the home had been decorated with various Christmas trees, tinsel and decorations. People also had small Christmas trees within their bedrooms. Although people confirmed they weren't involved in the decorations, they appreciated them. One person told us how the decoration in their room just appeared but how it was nice. Another person told us, "The girls did them, aren't they lovely." Throughout the home were various pictures of people who lived at home, creating a homely atmosphere. The registered manager told us, "When I walk in, I don't want this to feel like a care home, I want it to feel like people's own home and I feel we achieve that here."

People's rooms were personalised with their belongings and memorabilia. People showed us their photographs and other items that were important to them. People were supported to maintain their personal and physical appearance. A hair dresser visited the home regularly and care workers supported people to paint their nails. People were dressed in the clothes they preferred and in the way they wanted. Ladies had their handbags to hand which provided them with reassurance. Ladies were also seen wearing jewellery and makeup which represented their identity.

Friendships between people had blossomed while living at Vallance Residential Care Home. Throughout the inspection, people were seen sitting interacting together. We spent time sitting in the communal lounge with people. Two ladies spent time talking with us. One of them told us, "My name is (name of the person) and this is (their friend), we've become friends and we always sit next to each other." The two ladies then proceeded to place their heads together to indicate their friendship.

Care workers spoke highly of the person they supported. One care worker told us, "I look after people as if they were my grandparents. We give people choices around personal care, food, going out. People have lots of visitors. It's a small home, we are close to people and know what they like and prefer, whether its food, TV programmes or what they like to read. We are close like a big family." It was clear care workers had spent considerable time building rapports with people, getting to know their life history, personality, likes and dislikes. Each person had a 'my life' booklet which included key information which was pertinent to them and their life history. The booklet included information on where they were born, their hobbies, interests and things they enjoyed doing. For example, one person was a hair dresser up until they were 80 years old. Another person enjoyed model aircrafts, watching television and listening to the radio. Care workers commented that the booklet allowed them to build a rapport with people and engage with them. It also worked as a tool to help people reminiscence about their past.

Throughout the inspection, we heard laughter between people and care workers and care workers showed

gentleness and kindness. For example, one care worker said to a person, "Good morning (person), I've brought your tea, are you alright?" Another kind and caring interaction included, "Morning (person), oh you look lovely this morning," the person replied as they got off the stair lift at the bottom, "Thank you, (smiled) I'm just going for a little snack." Humour was also evident in interactions, for example one care worker said to a person, "You're a bit tired, have you been out on the town?" Both the person and the care worker then proceeded to laugh.

People's dignity and right to privacy was protected by care staff. People were assisted to their bedroom, bathroom, or toilet whenever they needed personal care that was inappropriate in a communal area. This support was discreetly managed by care workers, so that people were treated in a dignified way in front of others. Care workers also made sure that doors were kept closed when they attended to people's personal care needs. People were called by their preferred names and People confirmed that staff respected their individual space, knocked on their bedroom door before entering and respected their dignity. The home had a dedicated dignity champion who regularly attended dignity forums in the local area and told us how the sharing of ideas and experience was valuable.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Resident's meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes from the last meeting in October 2015 confirmed people spoke about naming their rooms instead of room one or two. Other topics for discussion included Halloween, Christmas, the menus and complaints.

Relatives told us they were free to visit and keep in contact with their family members. They said they were made to welcome when they visited. Throughout the inspection, we saw relatives coming and going, spending time with their loved ones in the communal areas or the person's own bedroom.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy and comfortable living at Vallance Residential Care Home. However, people had mixed opinions about the opportunity for social engagement and interaction. One person told us, "Painting leaves in different colours is quite a nice thing to do but the bingo isn't really a brain stretcher." Another person told us, "I enjoy singing, there's not a lot to do I thought there'd be more."

Guidance produced by the Alzheimer's society notes that 'meaningful activities should be enjoyable, and may be linked to hobbies or interests that the person enjoyed before the diagnosis of dementia. Activities such as taking a walk, cooking or painting can help preserve dignity and self-esteem. Some of the most beneficial activities can be simple, everyday tasks such as setting the table for a meal or folding clothes. They can help a person with dementia feel connected to normal life and can maximise choice and control. Some activities offer an emotional connection with others.' An activity timetable was in place which detailed what activities took place each day. Activities included, story making, radio or cds, card games, exercises in the lounge and Christmas card writing. One care worker told us, "There are loads of activities, have something planned for every morning and afternoon shift, it's the fun bit." Do quizzes, ball games, exercises, manicures, foot spas, cake decoration; get good response and it encourages conversation. "You can't just leave them sitting, watching TV. We put different kinds of music on, take people out for walks. The PAT dog comes in." Another care worker told us, "We put a high value on activities. It may be a simple thing, like watching a film together."

Although care workers spoke highly of the activities and the opportunities for activities, our observations and feedback from people did not match care workers comments. On the first day of the inspection, five people spent the morning in the lounge, the only stimulation between 09.00am and 11.45am was the television. At 11.45am, a care worker played a game of dominoes with one person before lunch. During that timeframe, care workers were in and out; offering cups of tea, but no care worker sat and interacted with people. In the afternoon, one lady asked if they could do something, which led to a quiz game being organised. On the second day of the inspection, four people were in the communal lounge between 09.00am until 12.00pm. The activity timetable stated an exercise session would take place at 11.00am, but this did not take place in the lounge. The provider subsequently told us the activity was held in people's own rooms. However, the activity timetable did not reference where the activity was to take place and people referencing the timetable would not have been able to see this. Again, the only form of stimulation was the television. We asked people if they could choose what they wanted to watch on the television. One person told us, "Not a case of choosing it's just on." However, the provider subsequently told us, "[Service users] enjoy helping around the home by setting the tables for meals, folding washing, offering biscuits/cakes to other service users at tea time, folding napkins and two of our service users even prefer to dust their own rooms. These everyday activities are practised on a daily basis and are not recorded on the activity sheet as it's a normal everyday thing."

As we spent time with people during the inspection, we heard people ask, 'what are we doing now'? Two ladies regularly asked, 'what day is it'. One person told us, "There isn't a lot to do, most people just watch television." A member of staff was overseeing activities and spoke with passion about the activities book

they had devised. The activities book included activities which could be done if the care worker only had five minutes. These activities included, offer a hand massage, and support a person to start an activity, go for a walk or water the pot plants. However, these five minute activities had not yet been embedded into practice and were not regularly taking place.

Care plans included detailed information about people's interests and hobbies, as ways to promote meaningful activities. For example, one person's care plan identified they enjoyed playing bridge; we asked them if they still played bridge? They told us, "I've got no one to play with." The provider subsequently told us that an attempt to create a bridge group for the games players in the home had been unsuccessful and the only other player had left. Activities included the hairdresser, church service or nails painting. Activities may not be applicable to everyone but staff tried to include those that wanted to participate. For example, men living at the home may not want their nails painted but staff took the opportunity to clean, cut and file their nails while, in addition, some women chose to have theirs painted. However, there was lack of consideration on how activities could be meaningful to people. Keeping occupied is an integral aspect of good quality dementia care alongside supporting people to maintain their identity and feel valued. For example, some people living with dementia , like to be involved with the running of the home such as folding laundry or laying tables. Though we did not hear or see these examples during our inspection the provider subsequently told us these were achieved with people who wanted to participate in them. Throughout the inspection, we could not always see how people were supported to feel valued and stimulated.

On the days of the inspection, we identified that some people preferred to spend all day in the communal lounge while other preferred to remain in their bedroom. For people who preferred to remain in their bedroom, we questioned how they received meaningful activities and stimulation. One person had aeroplane model kits in their bedroom. We asked if they spent time putting them together. They told us, "They may as well put them back in the cupboard there's no one to help me do them." Another person spent all their time in their bedroom and as part of their DoLS condition, work was required to ensure they received stimulation and interaction in their bedroom. Each person had an activity timetable which documented what they did each day activity wise. The documentation for this person recorded that they declined to join in the group activities in the communal lounge. We therefore questioned what engagement they were receiving. A member of the management team told us, "We always offer alternative activities and one to one but we don't record this." One care worker told us. "We offered one to one activities for this person. It worked for about a week but they just weren't interested."

Documents recorded where people had declined engagement with group activities. Activity timetable sheets were in place for staff to record what alternative activity was offered, but this was not completed.

Despite the above concerns, people did not appear agitated or distressed by the lack of activities and visiting relatives did not raise any concerns. However, consideration had not been given to the lack of stimulation and the impact this would have on people's cognitive functioning.

We recommend that the provider considers the National Institute for Health and Care Excellence quality standard for mental wellbeing of older people in care homes.

The risk of social isolation had not consistently been identified by the provider and acted upon. Nearly all of the people living at Vallance Residential Care Home were living with dementia or a mental health need. However, some people were not. For those people, concerns were raised regarding the risk of social isolation. One person told us, "I need a friend, someone on my wave length. I try to find someone to play scrabble or chess with but there doesn't seem to be anyone. Where I was before I used to organise quizzes

and things but here the motto is the staff do all the organising. More social things that appeal to me would be better." The provider subsequently told us that this person was, "Invited and encouraged to choose activities but she chooses to refrain. We have in the past asked this service user to organise quizzes as she had in her previous home but she was unhappy when she tried to do the quiz with the other service users and they were unable to answer the questions properly due to their dementia." We heard how this person goes out on a daily basis to visit the hairdresser, bank or the shops and this is recorded in their day diary.

Guidance produced by Social Care Institute for Excellence identified that personalisation meant thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. Personalisation focuses on the individual and how they want to receive their care. During the inspection, we identified that within some people's bedrooms were notices which documented, 'Tuesday is your bath day.' Care documentation also noted that every week on a particular day, the person would have a bath or a shower. One person told us, "They tell you when you have your shower and a hair wash. You get well dried and it's at least once a week. The carers choose, I used to have a bath but now I qualify for a shower." Another person told us, "I have a bath but would prefer a shower but the shower is downstairs and it would be too problematic for them to get me down there. My day is a Wednesday." We asked people if they could request a bath or a shower on another day. One person laughed and said, "No chance." Though the provider later told us that this persons 'pet phrase' was 'no chance' to a range of questions that could be posed to them. Care documentation failed to reflect if people were offered a bath or shower on alternative days. We brought this to the attention of the registered manager who told us, "I'm sure people could and are having baths or showers whenever they want." However, this could not be demonstrated or confirmed by people. People did not appear upset by this arrangement; however, it does not uphold the principles of person centred care. We have therefore identified this as an area of practice that needs improvement.

Each person had an individual care plan. Care plans were detailed and individual to that person. Each section of the plan covered a different aspect of the person's life, for example personal care and physical well-being; communication, mobility, personal safety, mental health, diet, religion and social activities. Care plans were reviewed regularly which included clear changes to the care plan and new objectives for staff to follow. For example, one person was experiencing incontinence when they were having bad days and suffering from high anxiety. The care plan had been updated to reflect this change and the new objective included for a referral to be made to the continence team which we saw had been made.

People and their visiting relatives felt confident in raising any concerns or complaints. One person told us, "The deputy manager is lovely, I had a problem with my curtains and I told (deputy manager) about it and she got them sorted out for me." Another person told us, "I'd always go to (deputy manager)." A complaints policy was displayed throughout the home and care workers told us they would support people to make a complaint. The provider had not received any written complaints this year. Where a verbal complaint had been received, it was acted upon within the set timeframe as described in the complaint policy. A member of the management team told us, "We take all complaints seriously."

Requires Improvement

Is the service well-led?

Our findings

People spoke highly of the deputy manager and felt the home was well-led. One person told us, "It's not perfect but nowhere is but you couldn't have a better person than (deputy manager) running the place." However, despite praise for management, we found Vallance Residential Care Home was not consistently well-led.

Various systems were in place for monitoring and reviewing the running of the home. These included health and safety checks, monitoring of staff sickness, infection control audits, reviews of care plans and gaining feedback from people. However, these systems were not consistently able to demonstrate how the provider identified when quality and/or safety was being compromised. We asked the registered manager what quality assurance framework was in place. They told us, "There should be various audits." We asked if they completed medicine audits, care plan audits or if they, as the registered manager, completed an audit to assess how they were meeting the requirements of the Health and Social Care Act 2008?. They commented, "Oh yes, we do various audits, we can find them for you." A member of the management team provided us with various folders labelled audits. One file was noted as the medicine audit. This included the audit from the local pharmacy and documentation to confirm that medicines had been received and checked in. Subsequent to the inspection, the deputy manager sent us a copy of the medication audit. The audit comprised the date medicines were received and the total quantity of the medicine received. The audit failed to explore whether storage facilities were correct, if MAR charts were completed correctly and if care workers were following policies and procedures correctly in line with the administration and disposal of medicines. Due to the absence of a robust audit, they had failed to identify that medicines were not consistently being recorded in the medicines received book.

There were systems and processes in place to consult with people, relatives and healthcare professionals. Regular satisfaction surveys were sent out, the last one being in November 2015. Feedback included, 'We are delighted we chose Vallance for my loved one.' Feedback from a professional included, 'Residents are well cared for and the home is clean and tidy at all times.' However, the provider was unable to demonstrate how they used the information to make improvements. The registered manager told us, "Maybe this is something I could delegate to a staff member to take responsibility for." The provider told us subsequently how, 'The registered manager, deputy manager and administrator hold joint meetings to discuss and analyse the data received from the feedback and deal with them directly by telephoning or speaking to the family during their next visit and record the outcome on the back of the satisfaction survey.'

Following an incident and accident, documentation was completed which looked at what happened, who saw it and the remedial action taken. However, mechanisms were not in place to monitor incidents and accidents on a regular basis to help identity any emerging trends or themes. The deputy manager completed a falls overview each month which considered who had fallen, the time, any injuries sustained and the action taken. However, there was no analysis or consideration if people were falling more at night or certain times of the day. For example, in July 2015, three people suffered falls at night time. In April 2015, one person had three falls that month. The absence of an incident and accident audit meant there was no overview, analysis or exploration of why people were falling at night or having regular falls. Under the Care

Act 2014, providers and registered managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents.

Due to the above concerns in relation to incidents and accidents not being monitored and the lack of a robust quality assurance framework, we have identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in post but delegated the daily running of the home to the deputy manager. Under the Health and Social Care Act 2008, a registered manager is the person legally responsible for managing and supervising the regulated activity. Care workers confirmed the registered manager popped in daily and spent time with people and was always on call. People were not consistently aware who the registered manager was but clearly felt that the deputy manager was in the charge. As the registered manager was delegating responsibility to the deputy manager we enquired how they had oversight of the regulated activity and ensuring the requirements of the Health and Social Care Act 2008 were being met. The registered manager told us, "I come in daily and check on things. If I find anything out of line, I discuss it with the deputy manager. We discuss everything together and no decision is made unless it's discussed with me." The registered manager also confirmed they had regular supervision with the deputy manager. On the second day of the inspection, we spent time with the registered manager. We asked them various questions in relation to the running of the home and the people living at the home. They were unable to tell us who was living with dementia and who was subject to a Deprivation of Liberty Safeguard. We therefore questioned what strategic oversight and mechanisms the registered manager had of the running of the service whilst the running of the service was delegated to the deputy manager.

Vallance Residential Care Home is one of the oldest running residential care homes in Brighton and Hove. The registered manager told us, "We opened in 1980 as I wanted to open a home for older people." Clear visions and values were in place and the registered manager told us, "This is a family run care homes and I pride myself on having a dedicated staff team." Family values were at the forefront of the running of the home and the home presented as calm and relaxed with a homely atmosphere. People commented they would recommend the home to other people. One person told us, "They take care of you, help you and do all you need to be done." Another person told us, "I would recommend it as it had been to me yes."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Incidents and accidents were not being monitored and there was a lack of a robust quality assurance framework.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons. Staff had not received the appropriate training as is necessary to meet people's needs