TN CARE LTD

Alphington Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 January 2018 and was unannounced. This was the first inspection of the service since it was re-registered in December 2017. We previously inspected the home in February 2017 when the home was registered under a different provider company. At that inspection we rated the home as 'requires improvement' because we found three breaches of regulation. These were; breaches of Regulation 11, Need for consent; Regulation 19, Fit and proper persons employed; and Regulation 17, Good governance. At this inspection we found some evidence of improvements by the new provider, but we also found two new breaches of regulations.

At the time of the registration of this new provider, an action plan was requested to demonstrate the new provider had taken account of the areas of improvement, including enforcement action that had been taken against the previous provider. This gave us information on what the new provider intended to do to make improvements.

Alphington Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and personal care for up to 28 older people. The home does not provide nursing care. At the time of this inspection there were 20 people living there, although two people were in hospital. The accommodation is situated over three floors. There is a shaft lift providing access to each floor.

There was 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.

Some aspects of medicine storage were not entirely safe. We found medicines received into the home had been placed in a vacant bedroom which was not locked. The medicines were left on the floor, bed and cupboard. We discussed this with the registered manager who took prompt action to ensure the medicines were safely stored. All other aspects of medicine administration and recording were found to be satisfactory. Staff who administered medicines were well trained and their competency was assessed and monitored.

Some records relating to people's care needs, including medicines, were not always stored securely. This meant records relating to people's personal and health needs were not maintained confidentially. We saw some care plans were left unattended on a desk in the lounge, and a cupboard holding care plans and personal records was not always kept locked. Medicine administration records were left unattended on top of medicine trolleys.

People's needs were met by sufficient staff on duty, although staff told us they were sometimes rushed. People living in the home and their relatives gave a mixed response when we asked if they felt there were

sufficient staff to meet their needs. Comments included, "Yes, as far as I am concerned"; "Sometimes, and sometimes not. Sometimes they are frazzled and pushed"; "If someone is ill, someone on leave" [staff are not as readily available]". The provider told us they were aware of staff feeling rushed and had asked the staff to complete an anonymous survey to gather their views. They carried out a review of staff routines shortly before our inspection and took actions to support staff, improve staff morale, and improve the delivery of care and services to people living in the home. Safe recruitment procedures were followed before new staff were confirmed in post. Staff were well trained.

People and their relatives were involved and consulted in assessing the person's needs and drawing up a plan to show how their needs should be met. Care plan documents were detailed, accurate and easy to follow. People received care and support from staff who understood their personal needs and abilities. Risk assessments were in place and regularly reviewed and staff knew how to support people to reduce the risks.

People's legal rights were respected and protected. People's capacity to make decisions was assessed and staff understood the procedures they must follow if people did not have the capacity to make important decisions about their lives.

People told us they received a caring service. Comments included, "The girls have been very good to me. I can't grumble". A visiting professional told us they brought in cakes for the staff when they visited the home, saying "I know how much they care for people here. The girls here are really caring." Staff knew how to communicate with each person. People could be confident they would receive compassionate care at the end of their lives from staff who had the knowledge and skills needed to meet their needs fully. Staff understood and respected people's preferred daily routines, likes and dislikes. Privacy and dignity was respected.

Overall people told us they were happy with the level of social stimulation and activities provided. Comments included "I go out with Age Concern, once a week. I go to Exeter for lunch and a little walk," "I sit in the summerhouse and watch the birds. I like the garden area. Art work, I like painting", "I sit. I sometimes get involved in art work. I have made friends with [name]. Sometimes they have classes. They do their best. There's an activities girl and she does activities such as I-Spy and we have someone who plays an accordion, reads poetry and plays a guitar." People's social needs were assessed when they first moved into the home and we saw staff sitting with people during the inspection playing board games, and supporting people to go out for a walk. The provider and registered manager had identified, and were in the process of introducing, new ways of supporting people to meet their social needs and involvement in daily routines in the home.

People were confident they could raise any concerns or complaints and these would be listened to, investigated and actions taken to address the issues. A person told us "I would speak to the staff or the manager. We have had no complaints." The registered manager told us that the complaints procedure was explained to every new person when they moved in. The registered manager personally visited each person every month and asked them if they have any concerns.

People lived in a home that was clean. Most areas were free from odours although we noted an odour in one corridor. Equipment was regularly serviced and maintained. Risks to the environment had been assessed and systems were in place to ensure risks such as fire were minimised.

People told us they felt safe. For example, one person said "I look after myself, so I have to feel safe. Yes, I am safe." Training records showed that all staff had received training on safeguarding. Staff confirmed they had received training and knew how to raise concerns if they felt anyone was at risk of harm or abuse.

There was a range of comprehensive audits and monitoring checks carried out on aspects of the service. The provider had a drawn up a programme to improve the care and support people received. We found improvements had been made since the last inspection, although the provider's monitoring systems needed further improvements to ensure issues relating to security of medicines, and security of confidential records we found at this inspection could been identified and addressed promptly by the provider's own quality assurance systems.

We found two breaches of regulations. 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

The service was not fully safe.

People could not be confident medicines received into the home were checked and stored safely promptly on receipt. Medicines were administered and recorded safely by staff who were competent to carry out the task.

People were protected from being looked after by unsuitable staff because safe recruitment procedures were followed.

People's needs were met by sufficient staff on duty. The provider had listened to staff concerns about staffing levels and was introducing new ways of working to improve the care and support people receive.

Risk assessments were completed to ensure people were looked after safely and staff were protected from harm in the work place.

Is the service effective?

Good

The service was effective.

People's legal rights were respected and protected. People's capacity to make decisions was assessed and staff understood the procedures they must follow if people did not have the capacity to make important decisions about their lives.

People received care and support from staff who were trained, supervised and supported.

People's needs were assessed and plans were in place to explain how staff would support them. People received care and support from staff who understood their personal needs and abilities.

People were involved in making decisions about their care and the support they received.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidentiality was not always respected because records relating to their health, medicines and personal care needs were not always stored securely.

People could be confident they would receive compassionate care at the end of their lives from staff who had the knowledge and skills needed to meet their needs fully.

People received support from staff who were kind, compassionate and respected people's personal likes and dislikes.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Care plan documents were detailed, accurate and easy to follow.

People were supported to follow a range of hobbies and activities, although opportunities to go out for a walk or into the community were limited.

People received care and support which was personal to them and took account of their preferences.

Arrangements were in place to deal with people's concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not fully well led.

People received a service that was monitored and checked to ensure continuous improvements. However, monitoring systems had failed to identify and address issues found during this inspection, for example safe storage of medicines and maintaining records securely and confidentially.

People received care from staff who were supervised and supported through an effective management structure.

People's feedback about the service was sought and their views were valued and acted upon.

Alphington Lodge Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 January 2018 and was unannounced. The inspection was carried out 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 care service. The expert by experience who accompanied us had experience of caring for an older relative.

During the inspection we spoke with the provider, the registered manager, deputy manager, six staff, 11 people living in the home, one relative and one visiting professional.

Before the inspection we looked at records we had received about the service since the service was registered. We looked at four care plans and daily records. We also looked at records relating to the storage and administration of medicines, staff recruitment records, staff training, staff supervision, and records relating to monitoring the service and quality improvement.

Requires Improvement

Is the service safe?

Our findings

At the time of the registration of this new provider, an action plan was requested to demonstrate the new provider had taken account of the areas of improvement, including enforcement action that had been taken against the previous provider. This provided information on what the new provided intended to do to make improvements.

At the last inspection in 2017, under the previous provider, we found the service had not always followed safe procedures when recruiting new staff. Some staff had been appointed despite no references having been received. The new provider's action plan at the time of registration stated had resolved the situation at the time of the inspection to ensure the situation would not occur again. At this inspection we saw that checks and references had been carried out on all new staff.

Some aspects of medicine storage were not fully safe. We found an unlocked room contained a large amount of medicines which had recently been received from the pharmacy. The medicines were spread across the floor, bed and chest of drawers. These included a medicine which required additional security. Whilst there was very little risk that people in the service would enter this room, it remains an unsafe practice, particularly for medicines that require additional storage. We informed the registered manager and they took immediate action to ensure the medicines were stored safely. However, we were concerned that safe systems were not in place to ensure medicines were checked and stored safely promptly on receipt into the home. After the inspection the provider gave us reassurances about the actions they had taken to ensure safe storage is maintained at all times in the future.

We also saw that liquid medicines had not all been labelled with the date of opening. Some liquid medicines had a 'shelf' life when opened so it is important to label the bottle with the date of opening.

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

We noted that the medicines administration records (MARs) did not contain a dated photograph of the resident. Photographs help to ensure staff know they are administering medicines to the correct person. The registered manager had identified this and told us that this was because "The photos had to be redone because we had requested better dividers from the pharmacy as part of ongoing improvement and these dividers had just been put in".

The home had a medicines policy that had been checked and updated in August 2017 to ensure that current best practice was reflected in the policy. The home used a four weekly blister pack system. Staff said they had a very good relationship with the pharmacy saying, "We are on a first name basis". During the inspection we saw an example of how the home was well supported by the local doctors' surgery and pharmacy. Staff contacted the doctor about a person they suspected may have a chest infection. The doctor prescribed a course of antibiotics. The antibiotics were delivered and subsequently administered on the same day.

Staff told us there had been no medicine errors in the previous six months. They were able to tell us what would happen in the event of a drug error to ensure organisational learning and prevent recurrence. At the time of our visit no one was in receipt of covert medicines (medicine which can be given following a best interest's discussion to people without them knowing). One person was self-medicating. Staff we spoke with were knowledgeable about procedures to be followed for people who required covert medicines, and those who wanted to administer their own medicines. The MAR contained details of any known drug allergies.

Staff who administered medicines were well trained and their competency was assessed and monitored. They worked a 'shadow' shift each medicine round and the morning medicine round twice. They received on line training in medicines management that included watching a video and answering questions after each training section. They complete a comprehensive training book and they also receive face to face training with experienced staff members. One member of staff that we spoke with told us "it takes about three weeks" and until they are both confident and competent. Managers undertake random observed competency assessments.

We checked a random sample of MARs against blister packs, expiry dates of topical creams/lotions, controlled drugs and 'just in case' medicine that is used for the relief of symptoms at the end of life. All were correct and in date. Staff showed us daily recordings of storage and fridge temperatures. This ensures that medicines are stored at optimum temperatures to remain effective.

Some people were prescribed a medicine that causes blood thinning. They received regular blood tests taken by district nurses. There was an effective system in place with the surgery to ensure staff knew the correct dosage to be given, and to prevent any errors with this medicine. We noted detailed instructions and dosage.

Where people were at risk of harm or illness, the risks had been assessed and were regularly reviewed. For example, where people were at risk of developing skin problems such as pressure sores, the risks had been assessed, medical advice had been sought, and care plans explained the care and treatment people needed. Staff told us that every person who was receiving topical creams/lotions was being reassessed by the district nursing team to ensure that only required creams and lotions were being administered. Records including body maps were held in peoples' rooms if they were at risk of skin damage. These instructed staff what topical cream/lotion to be used and the location to be applied. All gave specific and detailed instructions. Where people were at risk of falls, these were monitored and risk assessments reviewed to consider any actions needed. Independently mobile residents were offered a wrist alarm to request prompt assistance if needed, for example if they fell. Where people had a history of self-harm staff had considered the safety of the environment. A bedroom had been redesigned to avoid having any potential ligature points. Pressure mat wiring had been placed in trunking in the wall to prevent access to wires.

People's weight was monitored and medical advice was sought where a risk of weight loss was identified. A person told us they had lost weight but they were satisfied the staff were aware of this and were taking action to address this. They said, "They check it every day". The person was given supplementary high calorie drinks to help them maintain weight and said, "I have had three glasses today". A relative told us, "She has always been a fussy eater. It's causing them here a little bit of concern. They are monitoring her and checking her weight. She had (food supplement) the other day. They talk to us [the family] every day, the senior does, and keeps us up to date when we come in." One person who was underweight told us, "I was weighed a few days ago. I saw the doctor a few days ago."

People told us they felt safe. For example, one person said "I look after myself, so I have to feel safe. Yes, I am safe." We asked people if they knew who to speak with if they didn't feel safe and they all said they felt

confident they could speak to someone. For example, one person said "I am sure. The girls, they seem to listen very carefully to any problems. I feel I can talk to them." Another person said they would speak with "The person in charge, the manager. She is fine. My daughter can ring [the registered manager] any time to ask how I am getting on." Training records showed that all staff had received training on safeguarding. Staff confirmed they had received training and knew how to raise concerns if they felt anyone was at risk of harm or abuse.

People were protected from harm or abuse by safe recruitment procedures. The registered manager told us new staff did not work on their own until at least two satisfactory references had been obtained and a Disclosure and Barring Service (DBS) check had been completed. Employment records seen during the inspection showed that this process had been followed. The registered manager told us that whilst they were awaiting an employee's DBS, the person received on-site training, however, were always accompanied by a permanent member of staff. The person was also always placed as an additional member of the staff team. Staffing rotas reflected this as did the provider's recruitment policy.

There were sufficient staff employed to meet the needs of people living in the home, although some staff told us they were rushed at times, and some people told us staff sometimes did not always respond quickly when they asked for assistance. At the time of this inspection there were 20 people living in the home, (including two people in hospital). Staff rotas showed there was normally one senior care staff and/or the registered manager or deputy manager on duty each day plus three care staff. In addition a cook, cleaner and kitchen porter were employed every morning until 2pm. At the time of this inspection the overall dependency levels were not high, with just one person requiring two staff to assist them to move safely. There were no people with high dependency needs.

People living in the home and their relatives gave a mixed response when we asked if they felt there were sufficient staff to meet their needs. Comments from people living in the home included, "Yes, as far as I am concerned"; "Sometimes, and sometimes not. Sometimes they are frazzled and pushed"; "If someone is ill, someone on leave" [staff are not as readily available]"; "If we have a full staff it would be enough, but it's very seldom we have the full staff"; "Sometimes it seems adequate and sometimes the balance isn't quite right" and "The staff they have got here are excellent. They're pretty good. They always try to help, try to be there to do what needs to be done. They try to spend as much time as possible with individuals." Most people told us the staff responded quickly if they pressed their call bell to request assistance, although one person said "If I use my bell they [staff] come and say 'Yes, we will come and see you' and then they don't come back at all." They went on to say this didn't happen all the time. We spoke with the provider and the registered manager about staffing levels and they told us they had recently carried out a staff survey after staff had raised some concerns about staffing levels. They had carried out a programme to identify the cause of the problems and had recently taken a number of actions to change staff working practices. These had included discussions with staff about how to prioritise their work programmes, and they had started a staff support programme to help staff manage the changes. They also monitored call bell response times closely and had found these were satisfactory. After the inspection the provider sent us evidence of the progress they had made, and positive comments from staff about the new ways of working which showed staff were feeling less rushed.

People lived in a home that was clean. Most areas were free from odours although we noted an odour in one corridor. During a later check of the premises no odours were noted. We checked toilets and bathrooms and saw there was handwashing signage, liquid soap and disposable paper towels available in toilets and the kitchen. Disposable aprons were available in all areas, but no disposable gloves. We spoke with the provider and registered manager who told us these were checked and replenished regularly when required. This task was listed on the daily cleaning rota. They told us the stocks had run low on the day of the inspection but

the cleaning person did not want to disturb the registered manager during the inspection. They have reminded the cleaning staff they must notify the registered manager immediately in future if stocks of gloves are running low, and that they should not be worried about doing this on the day of a CQC inspection day.

People were provided with a safe and secure environment. Fire safety equipment was serviced and checked regularly. Staff received training in fire safety. Personal emergency evacuation plans (PEEPs) were in place for each person to ensure staff and emergency services knew how to assist people in the event of an emergency. Entrance and exit doors were kept locked and staff checked the identity of visitors before letting them in. We also checked the weighing machine and noted that it had been checked for accuracy on 12/04/2017 and was next due for checking in April 2018. An Environmental Health Officer inspected the kitchen two weeks before this inspection and found kitchen and food hygiene entirely satisfactory (rated five star). We also noted at lunchtime that some people complained about dirty cups. One person said "I'm not drinking out of this cup it's filthy". We looked at the cup and it was dirty inside. Staff immediately replaced the cup with a clean one and would remind staff or change a system to ensure cups clean in the future.

During the inspection we noted some radiators had not been covered to prevent the risk of burns. These were mainly in corridors although we also noted two unoccupied bedrooms had radiators with no covers on. We also noted two bedrooms had additional mobile electric radiators to supplement the fixed radiators. We were concerned the surface temperature of these radiators may present a risk, and trailing leads may cause a trip hazard. We spoke with the provider who checked the radiators after the inspection and told us they were satisfied the mobile radiators had low surface temperatures which meant their temperatures were below the maximum temperature as set out by Health and Safety Executive guidelines and were therefore safe. They assured us no people were at risk of burns or scalds. After the inspection they told us about the actions they had taken, and planned to take, to reduce the risk further. They planned to install low surface temperature radiators and radiator guards to radiators in corridors that were not covered at the time of this inspection. They also assured us they had reviewed the use of additional electric radiators for people and considered individual choice and needs. They had checked the main radiators in people's rooms to see if they could be adjusted to remove the need for additional heating.

Staff respected each person's individual needs, diversity and human rights. Before people moved into the service an assessment of their needs was completed with gather information about their backgrounds, religion, and beliefs. During the inspection we saw that each person was treated with respect and understanding. Staff respected people's human rights and diversity, The registered manager told us that training given to staff at the start of their employment included human rights and diversity. If a new person moved in whose diverse needs may not be fully understood by staff they would ensure additional training was provided. Spot checks on staff carried out by the management team ensured staff were treating people with understanding and respect. Staff were also questioned during these checks on their understanding of human rights, diversity, and also the Mental Capacity Act 2005.

Good

Is the service effective?

Our findings

At the last inspection, under the previous provider, we found people's legal rights were not fully respected and protected because people's capacity to make decisions was not fully assessed. At the time of the registration of this new provider, an action plan was requested to demonstrate the new provider had taken account of the areas of improvement. The action plan included the actions the new provider had taken to improve the understanding around people's legal rights being upheld and considered.

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We asked staff about their knowledge and understanding of mental capacity assessments, best interest meetings, safeguarding and Deprivation of Liberty Safeguards (DoLS). All the staff we spoke with were knowledgeable and confident in their understanding. Comments included, "Training is pretty good, I know about safeguarding, MCA and DoLS" and "I attended a level three safeguarding training on Monday and I have a level three MCA next month. I'm confident about DoLS". People told us they were confident staff always asked for their consent, and respected their right to make decisions. We saw staff seeking people's agreement and consent before assisting people with their care needs. One person told us "They say 'do you want…?' (before providing care and support)"

Care plan files contained information about each person's capacity to make decisions about important aspects of their lives. Mental capacity assessments had been completed where needed, and consent to care forms had also been completed where relevant. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted where appropriate.

People received an effective service from staff who were well trained. People told us they felt staff were well trained and knew how to meet their needs. Comments included, "I have help with washing and dressing. If I am not out of bed they will help me. If you don't want to get up you don't have to, I have a shower mostly. I had a bath yesterday. They know what they are doing"; "There's a nucleus [of staff] who know their job" and "They are well trained as far as possible."

The training records showed that new staff received induction training which lead to a qualification known as the Care Certificate. This is a nationally recognised qualification for care workers who have had no previous experience in a caring role. Seven staff also held a relevant qualification such as a diploma or National Vocational Qualification (NVQ) and we heard that further staff were about to gain qualifications in the future. Staff received a range of training and regular updates on health and safety topics, and topics relevant to the needs of people living in the home. These included safeguarding, moving and handling,

infection control, first aid, diabetes and dementia. Comments from staff included, "I had 36 hours of induction; it helped me settle in. I have had manual handling and first aid training" and "Training is quite good."

Records showed staff received regular support and supervision, however some staff we spoke with were unsure about the level of supervision they had received. Staff told us that staff meetings were held regularly and they felt they could raise any concerns or comments during these meetings.

Before people moved into the home an assessment of their needs was carried out. People and their families and representatives were involved and consulted in drawing up a plan of their needs. The care plans were reviewed and updated regularly. Monthly discussions were held with people and their family members so that the views, observations and suggestions were incorporated into the care plan with the individual's consent. The care plans gave staff sufficient information about each person's needs, preferences, and their daily routines to enable them to give people effective support. People told us staff provided care and support with the tasks they needed, at times to suit each person. Comments included, "Yes. I usually ask for a bath because I haven't got my own [in their room]. They let me know where I can go"; "You can go to bed whenever you want to. I normally go up at 9pm" and "Yes, there is usually somebody handy to help." One person told us the staff always took time to ask them what they wanted, saying "Absolutely, they are marvellous. They all do their job very well."

The care plans contained a variety of risk assessments covering areas such as nutrition and hydration, skin integrity, dependency assessments and falls risk. Where falls had occurred we observed detailed documentation including a falls calendar, falls prevention assessments, post falls observation records and future falls prevention plans and falls analysis. We also noted body maps that had been used to document any injuries sustained from a fall.

The staff sought medical advice promptly when needed. People were supported to attend medical appointments and receive regular check-ups. A relative told us, "The staff have called the GP for her breathing. There's an optician that calls. Her hearing is okay. She is going to the fracture clinic next week." A person told us, "Someone came and tested my eyes and I had some new glasses." Another person said, "The GP would visit. I have a dentist in Exeter. They have an optician, I am due probably this next visit." Care plans contained evidence of contact with medical professionals and any advice or treatment provided.

The registered manager and staff worked well with external healthcare services to help ensure people received a co-ordinated approach to their care. External professionals had recently commented about positive care delivery and a noticeable improvement in communication.

People's nutritional needs were well met. Most people we spoke with were satisfied with the quality and choice of the meals they received. People could choose where they wanted to eat their meals. There were two dining rooms, both attractively decorated and furnished and tables were laid with tablecloths, napkins and flowers. Staff went around to each person before mealtimes to let them know the meals on offer and to find out what they wanted. If people did not like the main choices they were able to ask for an alternative to suit their preferences. The menus were also written on a notice board in the corridor outside the main lounge.

We observed people eating their meal at lunchtime and found staff were attentive and people appeared to be enjoying their meals. Comments included, "Delicious. There is a choice, but whatever is put in front of me is delicious. You would just have to ask if it's something you don't like"; "The food is perfect for me. I eat anything"; "The food is very good. I don't like cheese so they give me something I do like. They will give me

something else"; "I don't like it sometimes. They come every day with the menu"; "It's as good as they can make it." The person went on to say that if they did not like what was on the menu "They find you something else, an alternative."

People also told us they were given plenty of drinks throughout the day. One person said, "There's tea, coffee or water. For hot drinks I come down here [to the lounge]. There's a jug of water in my room and I have my breakfast in my room." Another person said, "You have a glass and you can get water whenever you want it. There's a drink with breakfast, mid-morning, lunch, afternoon, and then tea."

The premises had been adapted to meet people's needs, although we noted some areas could be improved with some minor adjustments. For example, we noted that the hairdresser used an area in the main lounge and we were concerned about the disruption to other people using the lounge, and lack of privacy for people having their hair done. The hairdresser told they had asked in the past if a dedicated area would be possible, but was told there were no spare rooms. We spoke with the registered manager and provider who explained that the lounge had been used for hairdressing to help promote and encourage social interaction, however told us they would seek people's views about the use of the space. We also noted there were no curtains or blinds to one window in the lounge and a piece of paper had been stuck on the window to prevent people being affected by bright sunlight. We spoke with the provider and registered manager who agreed to consider providing blinds or curtains to this window.

People were able to move around the home easily. There was a shaft lift between each floor, and ramped access to the front door. Bedrooms were comfortably furnished and people were able to bring items of furniture and personal effects to make their rooms feel homely. The main lounge was situated on the lower ground floor, with access to an enclosed patio area with benches. There were large gardens where people could walk or sit in warmer weather.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, under the previous provider, we found staffing rotas were not always organised or monitored well to ensure staff were not just task-focussed in their care delivery, especially when the number of staff on duty was low. We also heard that some staff failed to respect people's privacy and dignity, for example by entering rooms without knocking and waiting for the person to respond. At the time of the registration of this new provider, an action plan was requested to demonstrate the new provider had taken account of the areas of improvement. The action plan included the actions the new provider had taken to improve the quality monitoring systems.

At this inspection we found staff treated people with dignity and respect, for example by knocking on doors before entering. However, we found staff did not always treat people's personal information in a confidential manner. We noted that records were not always stored safely to maintain confidentiality. In a corner of the main lounge there was a desk and filing cabinets where care plans and other records relating to people's care needs were held. We saw a person's care plan, with their photograph on the front page, was left unattended on the desk in the morning and could have been viewed by anyone coming into the room. At times throughout the day the cupboard containing care plans and other confidential information was left open with no staff in attendance. Medicine administration records (MAR) containing personal medical information about each person were left on top of the medicine trolleys in communal areas. This meant that people could not be certain that personal information would be held securely to maintain confidentiality.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received a caring service. Comments included, "The girls have been very good to me. I can't grumble". A visiting professional told us they brought in cakes for the staff when they visited the home, saying "I know how much they care for people here. The girls here are really caring." Staff knew how to communicate with each person.

We observed staff speaking with people in a caring and attentive manner. For example, one person was having trouble breathing and a care worker was sitting with her, talking to her and giving reassurance. When the person was feeling better the care worker said, 'I will be back' and one of the other care workers returned shortly after to check on her. Staff were smiling and cheerful in all their interactions with people.

Staff understood the importance of treating people with respect and privacy. We noticed staff knocking on peoples' doors before entering and preserving privacy when undertaking personal care. People told us, "Yes. To make sure, the staff always knock on the door before they come in", "I always have my door open. They always knock when I'm in the bathroom" and "They knock on the door". People told us staff respected their privacy when they had a bath, for example by helping them get into the bath and then leaving them to have a good soak before knocking on the door to offer assistance to help them get out.

We observed staff supporting people at lunchtime in a caring and considerate manner. Staff knew each

person well, and were aware of their likes and dislikes and were observant, recognising when people needed some assistance. For example, one person who had pureed foods due to the risk of choking was asked if they would rather use a spoon than a fork as they seemed to be having difficulty. Another person was asked if they would like to have their food cut up for them and another person was supported to turn their plate so the plate guard could be effectively used to trap food against the fork.

People told us their visitors were always made welcome, and they were able to see visitors in private if they wished. Comments included, "I can see them privately. They are made welcome by the staff." A relative told us they were able to speak with the person, "In her room, or the dining room if there's a larger number (of visitors)." One person told us their visitors, "usually come in here [lounge]. You can't discuss things with people with children running around. I would say 'can I go upstairs?'".

Good

Is the service responsive?

Our findings

At the last inspection, under the previous provider, we found care plan documents were not always detailed, accurate or easy to follow. We also found some aspects of people's social needs were not fully met, for example, opportunities to go out for a walk or into the community were limited. At this inspection we found care plans had improved. We also found people's social needs were assessed, and there was greater opportunity for people's individual social needs to be met, although there was room for further improvement. Whilst the new provider had not included details of this in their action plan provided at the time of registration, improvements had been made.

Overall people's social needs were met. People's social needs were assessed when they first moved into the home. Staff supported people to complete a document called 'This is me' that helped the staff find out about the person's history, family and interests. Some people told us they were happy with the level of social stimulation and activities provided. Comments included, "I go out with Age Concern, once a week. I go to Exeter for lunch and a little walk," "I sit in the summerhouse and watch the birds. I like the garden area. Art work, I like painting", "I sit. I sometimes get involved in art work. I have made friends with [name]. Sometimes they have classes. They do their best. There's an activities girl and she does activities such as I-Spy and we have someone who plays an accordion, reads poetry and plays a guitar."

An activities organiser was employed for eight hours per week. Care staff were expected to provide activities and meet social needs at other times. An activities calendar was displayed in the lounge area offering a variety of activities. There was also a planned schedule for people who wanted to go out for a walk. One person had an 'enabler' from Age Concern who planned to take them out for a walk when the weather improved. A person told us, "I go out. I walk down to the shops. Sometimes I go with [name]. The lady does all sorts of things – puzzles, games, art. The time goes so quickly. I visit my son and daughter in law." One person told us about a recent visit from a birds of prey company and showed us a photograph taken of them with a large owl. They said how much everyone had enjoyed this visit and also told us to look at the butterflies hanging by the window in the lounge that had been made and painted by the residents. However, one person told us, they felt there was little stimulation or conversation. We spoke with the registered manager and staff about how they met people's social needs, including opportunity for people to go out for a walk. They told us that every day seven to eight people had five to ten minutes of one-to-one time. During the inspection we overheard a person telling a member of staff they had missed their morning walk. The member of staff said, "Come on then, put your coat on and we can go out for a walk now." A member of staff also spent time playing board games with a person. We also noted a poster asking staff for ideas on how to involve people who live in the home. Several ideas had been recorded including, "let some plant some bulbs in the courtyard".

People told us they received a service that was responsive to their health and personal care needs. A person told us, "The staff are very good, very cooperative. They seem to notice when you need something."

Care plans contained detailed instruction on how people wanted to be cared for. One person had received a physiotherapy assessment following a recent fall and we saw the recommendations from the professional

had been implemented. This included ensuring the person always had a call bell within reach, using a pressure relieving cushion when sitting out and trying a smaller armchair when sat in the lounge area.

Staff were knowledgeable regarding peoples' care needs and were able to tell us in detail the care they required. Peoples' weight was regularly recorded and in the event of weight loss supplementary dietary measures had been implemented and staff encouraged 'treats' such as chocolate and crisps.

Staff understood the things that caused people to become upset, and knew how to diffuse potentially difficult situations, for example by offering reassurance or an activity the person might enjoy. They recorded each incident; what happened before the incident, the person's behaviour and what happened after the incident (known as ABC charts). This helped them understand the things that might cause the person to behave in that way, to consider how the staff supported the person at the time, and the resultant outcomes. This meant that people who had a history of presenting behaviour that may challenge staff or other people were able to remain living in the home safely.

People were protected from discrimination because staff understood each person's diverse needs. The initial assessment guided the assessor to look at the person's diverse needs. The staff were aware of people's religion and personal history and people were supported to attend religious services and maintain their beliefs. A person told us, "I go over to the Cathedral every Sunday morning with one of the ladies and a couple of other people." Another person said, "The vicar comes once a month." The registered manager told us they carried out regular spot checks on each member of staff, and during their observations they questioned staff of their awareness of equality, diversity and human rights.

People were confident they could raise any concerns or complaints and these would be listened to, investigated and actions taken to address the issues. The registered manager told us there had been three complaints in the previous six months. These had been recorded and the outcomes had been shared with staff to ensure that learning had taken place and actions taken to prevent similar problems occurring again. A person told us, "It's very good. They look after you quite well. If you don't like anybody you tell them and they do something about it." They told us about a concern relating to an agency member of staff, "They sent her back to the agency. They did it pretty quickly [dealt with the matter]." Another person told us, "I would speak to the staff or the manager. We have had no complaints." The registered manager told us the complaints procedure was explained to every new person when they moved in, in a way that they understood. The registered manager personally visited each person every month and asked them if they had any concerns.

People could be confident they would receive compassionate care at the end of their lives in line with their wishes. Most care plans contained some basic information about the person's funeral plans. The registered manager told us that when people were diagnosed as end of life they sat down with the person and their relatives to draw up and agree a more in-depth plan of their wishes for their care. Bereavement training was planned for the near future for all staff. A member of staff told us, "A senior spent time with me explaining what happens at end of life and it really helped". Training records showed that approximately half of the staff team had received end of life training and more was planned. We observed a number of thank you cards on a board outside the office expressing thanks from grateful relatives.

The provider was aware of the need to ensure people were given information in a format suited to their individual needs. They had recently updated their care plans to guide staff to assess each person's individual communication needs and identify how those needs should be met, including how information about the service should be provided. This included some prompts within the care plans around sight and hearing and how people should be supported by staff.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection the service has been re-registered under a new provider. While the ownership of the service has been transferred to a new company, the Nominated Individual remains the same.

At the last inspection, under the previous provider, we found the provider's systems to assess and monitor the quality of services to people were inadequate. The provider had a range of quality monitoring systems and audits but these had not used effectively to improve the quality of care and support. At the time of the registration of this new provider, an action plan was requested to demonstrate the new provider had taken account of the areas of improvement. The action plan included the actions the new provider had taken to improve the quality monitoring systems

At this inspection we found improvements had been made, although some aspects of the service continued to need further improvement. In addition, the provider's monitoring systems needed further improvements to ensure issues raised at the inspection could have been identified by the provider's own quality assurance systems. For example, the medicine audit had failed to ensure safe systems of medicine receipt and storage were always followed. The provider's monitoring had also failed to recognise records relating to people's health and personal care needs were not always stored securely to maintain confidentiality. Since the inspection the provider has assured us action has been taken to improve this. However, the provider's own quality assurance systems should have monitored and identified these issues.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a drawn up a programme to improve the care and support people received. This was called The Stepping Up Programme. This had been reviewed and updated on 26 January 2018, shortly before our inspection. They had identified areas where they could improve the support given to the staff, including supporting staff to become 'champions' in specific areas of care such as end of life, dementia and skin care. They had reviewed their training programme and identified areas for improved training. This had already begun, and showed dates of future training planned. They also identified a staff rewards programme to be introduced in the near future. The programme also identified a range of improvements for people living in the home, including ways of involving people in daily living activities in the home, such as helping with folding laundry, handing out post and washing dishes. They had introduced new ways of improving people's nutrition and hydration by offering snacks and introducing new foods for people to try. The outcomes were regularly reviewed and goals updated.

There was a range of comprehensive audits and monitoring checks carried out on aspects of the service. These included regular audits on medicine administration. Each person living in the home had a detailed medicine audit on a three monthly basis and routine audits of signatures on their medicine administration records (MARs) on a monthly basis. Staff told us that controlled drugs were audited on a weekly basis as well as being checked when administered.

Staff were consulted in the running of the home in various ways. A member of staff told us, "We have senior meetings, night staff meetings and carers meetings. We have just had an anonymous questionnaire via 'survey monkey' within the last two weeks. Supervision is given every 6-8 weeks. We also get an annual appraisal. I have settled in well. I'm confident this is a safe home"

However, there were also mixed views from the staff about the management of the home, staffing levels, and the level of support they received from the management team. Comments included, "Its hard work, it's constantly busy. You have to keep checking on staff, we always feel on edge, it feels like big brother. We don't have enough staff." Another member of staff said, "We haven't got a laundry person so carers have to do it. We spoke with the provider and registered manager who told us they had been aware of staff views and recently carried out an anonymous survey to gather staff views on the management of the service. They told us they had listened and had just begun to implement changes to the daily routines to enable staff to work more effectively with people. They had found some staff had 'doubled up' on tasks, and they had encouraged staff to spend more time sitting and talking with people rather than trying to find other tasks to do. They had also observed meal time working practices to help staff provide a more effective way of supporting people. After the inspection they gave us evidence of further monitoring of the staff and gathering of views. The evidence showed staff morale had risen, and staff were feeling less rushed and more supported.

There were systems in place to monitor people's care needs. Care plans were reviewed on a monthly basis and updated if required. We observed an audit in one care plan that had identified gaps in certain routine recordings and staff were able to tell us the action they had taken to ensure staff were recording regular risk assessments.

People and their relatives were involved and consulted on the day to day life in the home. A person told us, "I suppose there are meetings sometimes, but more like a get together in the lounge." Another person said, "Someone below the top person comes along and talks about information that you give them, and they do try to be casual. You can talk to them, have a chat to them." A person living in the home had been appointed as 'ambassador'. They went around to other people to ask their views, for example to find out if they enjoyed the meals, or if they had any complaints, grumbles or suggestions. They had received positive feedback about the recently introduced improvements to the food and fluids offered to people.

There was a registered manager in post. People told us they were confident they could speak with the registered manager at any time if they wanted. Comments included, "not relevant if the manager goes round every day and they think doing a good job The manager is doing their job very well," "Yes. I might and I might not [talk to her]. I think the way she runs this place is good." and "Everybody knows [the registered manager]. You can go to her in confidence. I don't go very often." People told us there was an open and friendly atmosphere in the home. Comments included, "[I'm] very contented. I have never yet heard a heated argument or any impatience." A member of staff said, "The [registered] manager is really good and helpful. I think people are safe here. It's definitely improving here. It's going in the right direction". The provider had identified a range of training resources for the registered manager and senior management team including the National Institute for Health and Care Excellence (NICE) guidelines and resources, and training initiatives with the Alzheimer's Society.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager and provider understood their responsibilities. They promoted the ethos of honesty and learned from mistakes, this reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to

care and treatment and apologise when something goes wrong. Inspection feedback was listened to and acted upon quickly to address the areas which we noted required improvement.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1), (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users were not protected against the risks associated with unsafe storage of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1), (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users could not be confident records relating to their personal care, medical needs and medicines prescribed to them would be stored securely to maintain confidentiality. The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care service users received was not always effective.