Alpha Care Castlemaine Limited

Castlemaine Care Home

Inspection report

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Date of inspection visit:
04 October 2018
05 October 2018

Date of publication:
05 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
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 Castlemaine on the 04 and 05 October 2018. This was an unannounced inspection.

Castlemaine Care Home provides care and support for up to 42 older people living with dementia. The care needs of people varied, some people had complex dementia care needs that included behaviours that challenged. Other people's needs were less complex and required care and support associated with mild dementia and memory loss. Most people were fully mobile and able to walk around the home unaided. At the time of this inspection there were 21 people living at the home and one person receiving respite care. Respite care is a short term stay.

Following our inspection in November 2015 warning notices were issued. The provider sent us an action plan that told us how they would address these. We inspected again in September 2016 to check the provider had made improvements and to confirm legal requirements had been met. We found the provider had not addressed the breaches of regulation found. We also identified further breaches of regulation in relation to staff support, procedures for reporting safeguarding matters and deprivation of liberty. The provider sent us an action plan telling us how they would make improvements. We met with the provider and received two monthly updates on progress made in meeting the regulations. We inspected in May 2017 to check what progress the provider had made to ensure legal requirements were met. We found in May 2017 the provider continued to be in breach of legal requirements. We continued at that time with the enforcement pathway. In September 2017 we found that improvements had been made and the breaches of regulation met.

This inspection found that whilst improvements seen in September 2017 had not deteriorated, there had not been the necessary improvements to change the rating to Good.

This is the second consecutive time the service had been rated as Requires Improvement.

Whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. This included updating care plans when an identified need or directive of care changed. For example, a deterioration in mobility and nutritional needs.

Not all care plans had been reviewed and updated to ensure they reflected people's current needs and associated risks. For example, changes to people's nutritional needs due to swallowing difficulties had not been recorded accurately and placed people at risk from not receiving the correct consistency of food and therefore cause complications such as choking or aspiration. Changes to peoples' mobility had not been reflected in the care plan or risk assessments so agency and new staff would not have the correct information to support people safely.

Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including

swallowing problems and risk of choking, and moving and handling. For example, pressure relieving mattresses and cushions were in place for those who were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes. Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new care staff, to ensure there was a sufficient number with the right skills when people moved into the home. There were systems for the management of medicines and people received their medicines in a safe way. All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns. Staff had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

All staff were expected to record the care and support provided and any changes in people's needs. The manager said all staff were being supported to do this and additional training was given if identified as required. People were supported to eat healthy and nutritious diets. Food and fluid charts were completed when risk of poor eating and drinking had been identified and showed people were supported to eat and drink. Staff had received essential training and there were opportunities for additional training specific to the needs of the service. This included the care of people with specific health needs such as diabetes and strokes. Staff had formal personal development plans, including two monthly supervisions and annual appraisals. Staff and the registered manager now had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles.

Activities were provided and were seen to be enjoyed by people who lived at Castlemaine. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals.

Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was good; the manager was approachable and they would be happy to talk to them if they had any concerns.

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

Castlemaine was not consistently safe.

People's safety was put at risk because some people's care plans and risk assessments were not up to date and had not reflected important changes to people's health and well-being.

There were systems to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks. However, there were some areas for 'as required' medicines that needed to be improved. Medicines were stored and administered safely.

There were enough staff to meet people's individual needs at this time. Comprehensive staff recruitment procedures were followed

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident their loved ones were safe and supported by the staff.

Is the service effective?

Good

Castlemaine remains Good.

People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink to maintain their health and ell-being.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

Castlemaine remains caring. Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated

with respect and dignity.

Each person's care plan was individualised. They included information about what was important to the individual and their preferences for staff support.

Staff interacted positively with people. Staff had built a good rapport with people and they responded well to this.

Is the service responsive?

Requires Improvement

Castlemaine was not consistently responsive. Not everybody had a care plan that reflected their current individual needs.

People's preferences and choices were respected and support was planned and delivered with these in mind.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Requires Improvement

Castlemaine was not consistently well led. Quality assurance systems needed to be further developed and embedded into everyday practice.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

The service worked in partnership with other relevant organisations.

Castlemaine Care Home

Detailed findings

Background to this inspection

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

We inspected the service on the 04 and 05 October 2018. This was an unannounced inspection. The inspection 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 care service.

We reviewed the information we held about the home, including previous inspection reports and the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the action plan provided following our last inspection. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which 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.

During the inspection we reviewed the records at the home. These included staff files which contained staff recruitment, training and supervision records. Also, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We looked at six care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and how they obtained their care and treatment at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we spoke and met with 20 people and five relatives to seek their views and experiences of the services provided at the home. We also spoke with the manager, provider, seven care staff and two members of ancillary staff. During the inspection process we spoke to health and social care

professionals that worked alongside the service to gain their views.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them. We observed the care which was delivered in communal areas and spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our inspection in October 2017 this key question was rated Requires Improvement because improvements were needed to ensure people's health needs were managed safely. This inspection found that further improvements were needed to ensure peoples' health needs were consistently managed safely and the rating for this key question remained Requires Improvement.

People told us they felt safe living at Castlemaine. One person told us, "I feel safe." Another person told us, "I like it here." Visiting relatives also confirmed they felt confident leaving their loved one in the hands of staff at Castlemaine. However, we found people's safety was put at risk because some people's care plans and risk assessments were not up to date and had not reflected important changes to people's health and well-being.

People's computerised care plans contained risk assessments for a range of daily living needs such as falls, nutrition, skin pressure areas. These documents were then printed off and held in the staff clinical room for easy access. However, not all care plans had been reviewed and updated to ensure they reflected people's current needs and associated risks. For example, one person had been re-assessed by a speech and language therapist (SaLT) who had changed the texture of food the person ate and this was not reflected in the person's risk assessment. Actions in associated risk assessments for this person wrote about giving the person drinks and food, which were no longer appropriate, due to their swallowing difficulties. One person who had regular respite care had minimal information in their care plan and risk assessments. We were told the person required a soft diet but throughout the inspection we saw this person eating biscuits and sandwiches. When we spoke with staff they said they had been informed by family of the need for a soft diet but were not sure why. The person helped themselves to non-soft food items throughout the inspection. The manager was to contact the placement team within Social Services for verification of nutritional requirements to ensure there was no health risk for the person. One person who lived with diabetes and required thickened fluids and a pureed diet had a care plan that stated monitor blood sugar levels, and if their blood sugar was low, give certain liquids, but no mention of thickening them as directed by the SaLT. It also states 'If blood sugar is 4 or above give slice of bread, two plain biscuits or crackers, a glass of milk' this did not take into account the SaLT recommendations for the person to have a pureed diet. This placed the person at risk of choking. The person did not have a risk assessment for choking.

Two people's mobility had deteriorated and their assessments had not been reviewed to reflect this. Both people were independently mobile, but now needed walking aids and one of them needed a wheelchair. Moving and handling assessments did not always describe to staff how to move people safely, such as pushing down on the chair to stand up. Staff undertaking mobility assessments were not trained to do so. We saw unsafe moving practices when staff helped a person to stand by using the person's trousers and another when they assisted a person from their chair by telling them to hold on to the walking frame to get them to an upright position. These practices were potentially unsafe to the person as they may lose balance. Additionally, not all staff had received practical moving and handling training.

The provider immediately arranged practical moving and handling training for staff. We spoke with staff and

the management team about these issues. The management team and staff were aware that care plans were not up to date. The provider had identified that losing senior staff over the past few months had had an impact on the care plans and had brought in an experienced senior member of staff from their other service as a deputy to assist the manager in addressing care plans. We asked that the information in people's care plans were updated to ensure new and agency staff had the correct information to deliver safe care.

The provider had up to date medicine policies, procedures and protocols which included 'as required' medicines (PRN) and covert medicines. The protocols for PRN pain management medicines gave clear guidelines as to when they be required and had visual cues for people who were not able to verbally communicate. We looked at people's PRN documents and saw that in the main they were competently completed. However, the PRN records for the use of sedatives such as lorazepam, did not evidence the reason for giving the sedative regularly and had not been evaluated for their effectiveness or benefit. We also found prescribed creams in people's bedrooms which were not stored safely and may be used inappropriately by the person or ingested.

We found certain areas of the premises were not clean and hygienic. The sensory room and a communal bathroom smelt strongly of unpleasant odours and were not clean. These were identified to the manager during the inspection and immediate action taken. Not all areas of the premises were safe and free of trip hazards. Certain bedrooms had rucked and frayed carpets which could potentially be a risk especially for those people who used walking frames.

The above evidence shows that care and treatment had not always been provided in a safe way as not all staff had the qualifications, competence, skills and experience to deliver care safely. Risk of harm to people had not always been mitigated as good practice guidelines for the safe moving and handling of people had not been followed. People's nutritional risks had not been appropriately managed. This meant that people's safety and welfare had not been adequately maintained at all times. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was adequately clean apart from those areas mentioned above, and there were regular audits to make sure cleanliness levels were maintained. Staff told us that there had been an audit of chairs which had resulted in some chairs being removed. People told us, "No complaints." Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or aprons when needed.

There were appropriate arrangements for the safe management and administration of medicines. The provider's medicines management policy covered all key areas of safe and effective medicines management. Staff were able to explain how the system worked and were knowledgeable about people's medicines. Medicines were stored appropriately and temperature checks for treatment rooms and clinical refrigerators were recorded on a daily basis. People's medication administration records (MAR) showed the medicines a person had been prescribed and recorded whether they had been administered or the reasons for non-administration. Overall the records we viewed were up to date with no omissions. Staff who administered medicines were trained and were required to undertake an annual competence assessment. Medicine audits were up to date.

As far as possible, people were protected from the risk of abuse or harm. Staff had received safeguarding training, they demonstrated an understanding of different types of abuse and described what action they would take if they had any concerns. Staff had read the whistleblowing policy; they stated they would report any concerns to senior staff on duty and the registered manager and they were confident their concerns

would be dealt with. Staff were also aware they could inform the local authority or CQC and the contact details for the relevant bodies were available in the office. People, relatives and staff said they had not seen anything they were concerned about. Relatives told us of resident and family meetings and an open door policy enabled them to raise any concerns with the acting manager or senior staff at any time.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There were good systems to ensure moving and handling equipment was serviced, checked and maintained to a safe standard. These included checks on the hoists and slings, weighing scales, wheelchair maintenance and the lift. There were monthly checks of the nurse call system and window restrictors. Water temperatures had been tested weekly and portable appliances annually. Checks were also carried out in relation to gas and electrical servicing and legionella. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Since the last inspection safe and robust recruitment processes had been sustained. We looked at four staff files. All had Disclosure and Barring Service check (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. At least one reference was in place before the start date, usually two and there was evidence of chasing up references. The checklist stated one reference must be from the person's most recent employer. All had a good record of their interview with the acting manager and provider, with appropriately targeted questions relevant to the post and the needs of people in the home. All had full employment history and evidence of checks on identity. Where people had certification of in-date training from previous employers, this was accepted and recorded in the training matrix and then booked in for further training. Staff were issued with a staff handbook and The General Social Care Council (GSCC) code of practice.

There were enough staff working in the home at this time to meet people's needs. The accident and incident audits for the past year had not identified any trends that identified insufficient staffing at any certain time. People told us the staff were always available and we saw that staff responded promptly when people used their call bell for assistance. One person said, "I get help when I need it." One visitor said, "Staff are busy but they are good." Staff told us there were enough staff to provide the support people needed. One member of staff said, "It is busy but manageable." Feedback from people and our observations indicated that sufficient staff were deployed in the service to meet people's needs. Staff were available for people, they were not rushed and supported people in a calm manner. We saw staff sitting with people in communal areas and spending time with people. People also approached staff for support throughout the inspection process and were always engaged with promptly. Agency staff were used to cover shifts and the provider ensured that as much as possible they were regular staff so as to provide continuity to the people who lived at Castlemaine.

Staff knew each person's individual traits and were quick to respond to signs of distress, agitation and discomfort with appropriate techniques. Care plans also contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure damage. One person's care plan directed staff to offer a change of position every two hours as they were at high risk from pressure damage.

Good

Is the service effective?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

All of the staff had received training in MCA. Consent to care and treatment was sought in line with the law and guidance. Processes were followed to assess people's mental capacity for specific decisions, for example, in relation to the use of sensor mats or bed rails. Meetings to reach decisions on behalf of people and in their best interests were carried out appropriately.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). All appropriate applications to restrict people's freedom had been submitted to the DoLS office as per legal requirements. The manager had considered the least restrictive options for each person. One person occasionally refused medicines. A discussion had been held with the person's family and the pharmacist to check if the medicines could be given covertly and this had been agreed. This decision was respected.

People received effective care as staff had received appropriate training to meet their needs. Staff training included safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. They also received additional training specific to people's needs, for example, dementia care, nutrition and training on equality and diversity. Additionally, there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One staff member told us, "I am doing lots of training, the induction was really good and I shadowed other staff until I had finished my induction." They also said, "I am still finding my feet, but everyone has been very patient with me when I asked questions."

One staff member told us they had recently completed online training on dementia. They said the course had said music and singing was beneficial They had not considered this technique before but recognised this might be appropriate for some people. Another staff member told us they sometimes used music as a method of helping one person to relax when personal care was provided and this was effective for them.

Staff received supervision regularly. Feedback from staff and the manager confirmed formal systems of staff development, including an annual appraisal, was undertaken. Staff told us they felt well supported. One staff member said, "We are all clear about what we have to do but I can go to any of the management if I have a problem. The care here is very good." Agency staff confirmed they were shown around the building when they came to the home first and the fire procedure was explained. The manager said they confirmed with the agency that all staff used had the training and skills to work at Castlemaine.

People's needs were assessed and care, treatment and support was delivered in line with current legislation and evidence-based guidance that achieved effective outcomes. People's skin integrity and their risk of developing pressure wounds had been assessed using a recognised pressure damage risk assessment tool

and a Malnutrition Universal Screening Tool (MUST). These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses.

People's nutritional needs were met. They told us they enjoyed the food and had enough to eat and drink throughout the day. We saw that people received snacks throughout the day, such as sandwiches. This was because it had been noted that some people were gradually losing weight. One person said, "Food is very good, plenty to eat." Other comments included, "The food is nice and there's choices as well," and "There's plenty to eat, more than enough and lots of choice of drinks." Nutritional assessments were in place and identified if anyone was at risk of malnutrition, dehydration or required a specialised diet. Information about people's dietary requirements were in their support plans and in the kitchen, for the cook. Information for the cook was updated daily so they were aware of people's individual requirements. The chef was very knowledgeable about people's nutritional requirements and was committed to producing good, healthy and nutritious food. All the food was attractively served and this included the pureed and soft meals. A choice of meals was offered and alternatives were available. Where necessary people's food and fluid intake was recorded. Fluid records were consistently completed.

Most people chose to eat their meals in the dining room/lounge area and the menu for the meal was displayed on a board. The tables were laid with table cloths, condiments and cutlery. People were able to sit where they wanted to and we observed people felt comfortable eating at their own pace and in their own time. This made mealtimes a sociable occasion. People's individual preferences were taken into account when planning the menus and alternatives were always available. When people had finished their meal, staff checked they had eaten enough and second helpings were offered. There was a choice of hot and cold drinks available throughout the day and fresh fruit was available. Everyone we spoke with said they enjoyed their meals. People's weight was monitored monthly and staff sought advice as required.

Staff provided care and support to people with swallowing difficulties, for example following a stroke. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking and aspiration as thickened fluids are easier to swallow. Staff were responsible for the management of thickened fluids and guidance was in place on the required texture of thickened fluids. Input from dieticians and SaLTs were also sourced. Staff told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, we offer sandwiches as well."

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. Not all rooms had an ensuite facility however there were specialised baths and wet rooms for communal use. People were supported to move around the home and were assisted to remain mobile by staff. All floors of the service were accessible via a lift. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using either stand aid hoists or electrical hoists. The garden areas were safe and accessible to people who lived at Castlemaine.

Good

Is the service caring?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

Throughout our inspection staff interacted positively with people and spoke calmly and with respect. One visitor to the home told us, "The regular staff are patient, kind and caring." Another visitor said, "The Staff are kind and compassionate and I have no hesitation in approaching them to talk about my mother." One person told us staff were, "Very kind and gentle." Another said, "I get on well with all the staff they are excellent." When people needed assistance to move from one area to another, staff explained to them what they were doing and offered reassurance throughout. One visiting professional told us, "From my observations, staff do positively engage with residents and are polite and caring."

We observed staff chatting to people in communal areas and engaged with them in meaningful conversation. Staff knew people's names and talked with, and listened to, people in a kind and caring manner. People were well presented and looked comfortable in the presence of staff. We saw that staff were very kind and thoughtful and interacted with people in a friendly and reassuring way. One person told us, "I like the staff, they are very caring."

People were treated with respect and dignity. The home had a relaxed atmosphere. People responded positively when staff approached them in a kind and respectful way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Really kind and patient" and, "Nice atmosphere, always upbeat." One person told us staff didn't try and rush them to get everything done. One staff member said, "The staff team is really focussed on caring, we have all learnt from the past experiences and really want to do our best, our residents deserve the best."

People were supported by staff who treated them with dignity and respect. Within each care plan there was advice about ensuring people's privacy and dignity was maintained and ensuring people were encouraged to make preferences in how they were supported. Staff gave us examples of how they maintained people's privacy and dignity. They said they knocked on people's doors and waited for a response before they entered the room. They told us they maintained people's privacy and dignity by always ensuring doors were closed when personal care was given. When food was served to people this was done in a way that met their individual needs and maintained their dignity. For example, staff sat at the same level as people, maintained eye contact, and they spoke with people as they provided support.

When one person needed immediate support with personal care a staff member provided a discrete explanation to the person and guided them to a private area where this was provided. Their calm and reassuring approach enabled what could have been a cause for embarrassment for the person, to be dealt with quickly and with no loss of dignity. We saw another occasion when one person's clothing became stained and staff took the person to their room to assist them to change their clothes.

During our inspection we observed people were treated with kindness and compassion. There was a very

relaxed and calm atmosphere in the home and staff had a good rapport with people. People's relatives were encouraged to personalise bedrooms to reflect the people's individual tastes and interests. Bedrooms in the premises were gradually being redecorated and refurnished. Care plans included information about people's needs, choices, personal histories and interests. For example, for one person the care plan stated, "Give time to allow her to find the correct words and use body language to help her understand." We observed staff talked and communicated with people in a way they could understand.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. Newspapers and books were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. One relative told us, "We are always welcomed and feel at home, tea, coffee and cake is always offered."

During the mealtime we observed staff giving people choices with their meals and drinks. They encouraged people to eat independently and support was offered and if accepted, provided in a way that suited each person. For example, some people needed gentle prompts to remind them to eat. Other's needed support to cut their food and some needed support to eat. Support was provided discretely.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection this key question was rated Good and this inspection found it had deteriorated to Requires Improvement. This was because people had not always received person specific care as their care plans had not been updated to reflected changes to their health and social care needs.

People's needs had been re-assessed before the last inspection in September 2017. As already identified people's reviews had not always been updated to reflect changes to their health over the past six months. For example, the care plan and continence risk assessment for one person stated the person took responsibility for their stoma (an artificial opening that allows faeces from the intestine to pass) but when talking to staff and reading daily notes the person was now unable to do this and there was no guidance for staff to manage this task within the person's care documentation. Throughout their documentation there was reference that the person's spouse was involved in discussions and care plan reviews. A management plan for behaviours that challenge stated that if the person was to become distressed and agitated, staff were to call the person's spouse on their mobile. However, the person's spouse had passed away and this was not reflected anywhere within the documentation and how staff managed the persons grief or that the person's spouse no longer visited. Another person's risk assessment talked about their blood sugar levels and what to do if levels dropped below a certain point, but staff did not check blood sugar levels and told us they never had so would not know when their levels had dropped to this point. On talking with staff we were reassured that the staff on duty were aware of people's care needs, however due to the use of agency staff and new staff there was a potential that people would not receive the care required, therefore this was an area that requires improvement.

We received confirmation from the provider that the shortfalls in the care plans were rectified within 48 hours and all necessary documents were updated to ensure the information recorded was reflective of people's current needs.

People's needs had been assessed before they moved into the home, to ensure they could provide the support and care needed to meet their needs. The information from the assessment was used as the basis of the care plans and there was evidence these had been written with the involvement of people, and their relatives if appropriate. Records confirmed that people and their families or representative had agreed with the information recorded, as well as consent for photographs, sharing the information with external professionals and for reviews of their care plan.

Despite the above issues, the quality of information originally documented on the computerised care plan system was person specific and in line with people's preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw that staff had spoken with families and friends. Staff told us, "People change and we adapt their care accordingly with help from family, friends and our staff." We also found some good examples of care plans that and the guidance for staff was clear.

Activities at Castlemaine were planned and a programme displayed in the communal areas of the home.

Activities included pampering sessions, exercise to music, dance and board games. External entertainers and visits from pet therapy animals were popular with people and arranged on a regular basis. People and families felt that staff did a good job but felt more stimulation would be beneficial for people." One visitor said, "There was a sensory room but it was ruined, it would be nice to see it back, a room to relax in when its busy and noisy would be lovely for mum." Another visitor said "It's nice to see carers' dancing with my mother, she loves it." They also said, "The film afternoon is really popular, the golden oldie films." There was a dedicated activity person who had been in post for five weeks and was beginning to create life books for each person. Most of the activities at present were either one to one or small groups depending on who wanted to join in. We saw an exercise class that started off well attended but gradually people lost interest when they tired, but people enjoyed the bits they were involved in. People were supported to play board games and dominos and encouraged to paint and colour and we observed that people enjoyed these activities.

When the activity person was engaged with one to one sessions, staff took over and staff sat with people and either chatted or engaged people. There were some lovely interactions between people and staff. Music was playing in the communal area and staff were seen dancing with people who obviously enjoying themselves as they had big smiles on their faces. Other people were seen tapping to the music in their chairs. One person had a teddy which she was holding up dancing to the music and smiling. People had forged friendships and were sitting together and chatting which staff encouraged and supported. People that could, accessed the communal areas as they wished, and walked around with their companions or with staff. Staff spent time sitting with people especially when they became agitated.We saw that people responded to familiar faces and soon calmed down.

The activity person was trying to organise more trips out for people to enjoy as a group. She told us "It's important for people to go out, the garden has been popular with some people and is really safe for them, but to go out regularly is something." One person told us they had been to Hastings Pier to talk to the Fishermen and was looking forward to visiting a fish farm. Another was supported to go out for coffee and shopping. This demonstrated that people were supported to continue with outside interests and access the community. At present whilst still getting to know people, she was only taking one person at a time. The provider and staff told us that activities were an area they were committed to constantly improve. The provider confirmed they would be providing support and training to the activity person to improve activities and provide a more stimulating environment. This would include introducing more interactive equipment for people and providing quiet areas.

Regular staff and resident and family meetings were now being held and we saw that times of meetings were displayed; details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan stated they had sent out surveys and regular meetings were held, they included reference to laundry and meals as points of discussion. We saw that action points were recorded and people, visitors and staff updated.

The staff team had a good understanding of the Accessible Information Standard and discussed ways that they provided information to people. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The activity programme was available both in written and pictorial format. For those who had a visual impairment staff used large print and said they could provide information on tape so people listen to the information.

People were supported with their specific communication needs. Staff understood how to use pictures and objects of reference where appropriate on a one to one level. Some people also used hand signals to

communicate. Each person had a communication care plan which detailed the difficulties people had and contained clear guidance for staff to follow on how to communicate effectively and be responsive to individual needs.

A complaints procedure was in place and displayed in the reception area of the home. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan." Another said, "I would tell one of the staff if I was unhappy." Complaints were recorded and responded to in line with the organisational policy. A complaints log was kept and monitored by the acting manager and provider. The complaint log showed complaints were investigated and responded to appropriately.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, this key question was judged to be Requires Improvement as time was needed to embed robust quality assurance to drive and sustain improvement. This inspection found that it remained Requires Improvement. We found improvements in some areas but they had not been consistent and the systems in place to assess the quality of the service provided or to monitor and mitigate risks to people were not fully implemented or embedded into practice.

The registered manager left the service at the end of May 2018. A manager had been recruited and had worked at the service since June 2018. The provider had informed us that discussions about leadership in the home and registration were happening at this time. The lack of a registered manager is an automatic limiter to this key question being rated as Good.

The manager was supported by the provider and a newly appointed deputy manager. It is acknowledged that the service has had a difficult six months. The provider and staff had worked hard over the past year to drive improvement but the leaving of senior staff had impacted on the improvements being sustained. This was due to new staff being recruited and a change of leadership within the service. We saw that staff were committed to improving the service. The provider and management team were open and transparent about the problems they had experienced with staffing and the need to use agency staff to ensure people's safety. The recruitment of staff was progressing and we met with staff that had just started work. One new staff member said, "I was made welcome and the induction is going well, I feel supported by all the staff."

The systems to assess the quality of the service provided or to monitor and mitigate risks to people were not fully implemented or embedded into practice. There was a range of audits and these were carried out; however, these had not all been effective in bringing about improvements. The provider had not ensured all records relating to the service were accurate, complete and up to date. Risk assessments and care plans for people had not been updated to reflect changes to their health and well-being and this had not been identified through the audit system for care plans. People's care plans had not been updated to reflect significant changes to their health, in moving and handling requirements, nutritional needs and communication. We saw some reviews had been undertaken but because the reviews were undertaken by new senior staff, they had not picked up on changes to people's health due to not knowing their history. This had been a learning experience for all staff in that care plan reviews should be shared with staff and discussed. This was an area that requires improvement.

Gaps in staff training had been identified by the provider and we were assured that this was being taken forward robustly to ensure peoples safety.

Records and documents pertaining to the running of the home, which included health and safety checks were all up to date and readily available at the service. Feedback was gained from people by annual satisfaction questionnaires and by regular resident and family meetings. The provider visited the service a minimum of three times a week to give support and monitor improvement. Visitors and people told us, "Yes the staff listen, the manager is very hands on and listens," and "The care here is good. I have nothing to

complain about, they sort out problems."

There was an open culture at the service. The manager was visible and worked at the service 9am until 5pm, five days a week. She was beginning to have a good understanding of people and their individual support needs. She said, "It is always difficult taking over as manager and getting to know people and staff, but we will get there. Lots of things I want to introduce but it will not happen overnight, but slowly and safely." The manager told us that they had an open door policy which had really supported the home to be able to rectify any concerns before they became bigger issues and offer support in any areas where it may be needed. One visitor said, "A few changes lately, key staff have moved on, but the care is still good and the staff new and old are nice." Staff told us they enjoyed working at the service and told us, "Very happy here, well supported, some training still to do, I think I'm due my moving and handling training soon," and "I like working here, lovely residents."

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. Call bell responses were monitored to ensure staffing levels were sufficient. On discussion with the registered manager, future actions of persistent falls may include looking at a more suitable room location for certain people. This would only happen if it is in the best interest of the person. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff are knowledgeable about the people they care for and want to get it right" and, "They listen, take advice and act on the advice."

Relatives felt they were able to talk to the manager and staff at any time and the relatives' meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it." The management team were constantly looking at ways to involve people and their families in the running of the home, this included inviting them to regular meetings and inviting them to give feedback.

The health and social care professionals we contacted did not express any concerns at the time of our inspection. External health care professionals such as the GP and dietician, contacted, informed us that staff were kind and followed their guidance. The provider was aware of the requirement to inform the Care Quality Commission of events or incidents which had occurred at the service. The commission had received appropriate notifications, which helped us to monitor the service. From April 2015 it was a legal requirement for providers to display their CQC rating. The provider was displaying their rating correctly.

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 The provider had not ensured care and treatment had always been provided in a safe way as not all staff had the qualifications, competence, skills and experience to deliver care safely. Risk of harm to people had not always been mitigated as good practice guidelines for the safe moving and handling of people had not been followed. People's nutritional risks had not always been managed safely. Regulation 12 (1) (2) (a) (b) (c) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.