Tamaris Healthcare (England) Limited

Roseworth Lodge Care Home

Inspection report

Redhill Road, Roseworth Estate TS19 9BY
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Ratings

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

Overall summary

This inspection took place on 25 August 2015 and was unannounced inspection, which meant the staff and registered provider did not know we would be visiting.

Roseworth Lodge provides care and accommodation to a maximum number of 48 people. Accommodation was provided over two floors. Bedrooms are single and have ensuite facilities which consist of a toilet and hand wash basin. On the first floor of the home there is a designated unit for 12 people who are living with a dementia type illness. There are communal lounge areas on both the ground and first floor of the home. The home is close to shops, pubs and public transport.

The home had a manager in place who had been working there as the manager for two weeks and was going through the registration process with the Care Quality Commission (CQC) to become a registered manager. A registered manager is a person who has registered with the CQC 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.

At the last inspection in October 2014 we found the registered provider did not meet regulations related to the management of medicines and consent to care and treatment. The registered provider sent us an action plan that detailed how they intended to take action to ensure compliance with these two regulations.

At this inspection we found that since the inspection of the service in October 2014, appropriate systems were

Summary of findings

now in place for the management of medicines so that people received their medicines safely, some minor issues still needed addressing and consent to care and treatment was sought.

We found that supervisions and appraisals had only taken place for some staff members and training was not fully up to date. The new manager had already recognised this and put an action plan in place.

We saw that people were involved in activities.

People nutritional needs were met and their individual preferences and wishes adhered to.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. Not all staff had received training in safeguarding but said they would be confident to whistle blow [raise concerns about the home, staff practices or provider] if the need ever arose.

Assessments were undertaken to identify people's health and support needs and any risks to people who used the service and others. Plans were in place to reduce the risks identified. Care plans provided evidence of access to healthcare professionals and services.

There were sufficient numbers of staff on duty to meet the needs of people using the service on the day of inspection but the manager felt that one more member of staff on a morning and evening was needed. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

All of the care records we looked at contained written consent for example consent to photographs and the care provided.

Any accidents and incidents were monitored by the manager to ensure any trends were identified. This system helped to ensure that any patterns of accidents and incidents could be identified and action taken to reduce any identified risks.

The home was clean, spacious and suitable for the people who used the service.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced such as fire equipment and water temperature checks.

The registered manager had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The manager understood when an application should be made, and how to submit one. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager and looked at records. We found the provider was following the requirements in the DoLS. Not all staff we spoke with had a clear understanding of DoLS. We discussed this with the manager who said they would look into simplifying this for the staff and discussing it further at group supervision.

People who used the service, and family members, were complimentary about the standard of care. Staff told us that the home had an open, inclusive and positive culture.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible..

Care records showed that people's needs were assessed before they moved into the service and care plans were to be replaced with a new Four Seasons Care Plan which we were told would be less confusing.

The service had a comprehensive range of audits in place to check the quality and safety of the service and equipment

The registered provider had a complaints policy and procedure in place and complaints were documented on the services DATIX [computer] system. We could not get a full list of complaints due to some being documented in DATIX incorrectly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Staff were knowledgeable in recognising signs of potential abuse and would report any concerns regarding the safety of people to the registered manager.

There were sufficient staff on duty to meet people's needs, the manager had identified where improvements to staff levels could be made. Effective recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

Medicines were managed and stored safely. PRN protocols needed to be put in place and two signatures on handwritten MARs.

Appropriate checks of the building and maintenance systems were undertaken

Requires Improvement

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

Training was not fully up to date and this had been identified by the manager.

Formal supervision sessions and appraisals with some staff had taken place. The manager had recognised the need for more structure with this.

The manager demonstrated a good understanding of the Mental Capacity Act 2005 and DoLS, although staff needed extra training on this.

People were supported to have their nutritional needs met and were provided with choice.

People were supported to maintain good health and had access to healthcare professionals and services. Consent was sought.

Requires Improvement

Is the service caring?
The service was caring.

People told us that they were well cared for. We saw that staff were caring and supported people well.

People were treated with respect and their independence, privacy and dignity were promoted.

Wherever possible, people were involved in making decisions about their care and independence was promoted.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People's needs were assessed and care plans were produced identifying how to support people with their needs. Care plans were to be updated.

We saw that people were involved in activities.

Appropriate systems were in place for the management of complaints. Although not always inputted correctly on the computer system. People we spoke with did not raise any complaints or concerns about the service.

Is the service well-led?

Good

The service was well led.

Staff told us that the manager was approachable. People and relatives were starting to get to know the manager.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us that the home had an open, inclusive and positive culture.

Roseworth Lodge 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 was 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 25 August 2015 and was unannounced. This meant the staff and the registered provider did not know we would be visiting.

The inspection team consisted of two adult social care inspectors, one specialist professional advisor and an expert by experience. A specialist professional advisor is someone who has a specialism in the service being inspected such as a nurse. 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 had experience in caring for older people living with dementia.

Before we visited the home we checked the information we held about this location and the service provider. For example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and district nurses. No concerns were raised by any of these professionals.

We did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 12 people who used the service and five family members. We also spoke with the regional manager, the manager, three nurse's, four care workers, the head cook and the activity coordinator.

We undertook general observations and reviewed relevant records. These included three people's care records, four staff files, audits and other relevant information such as policies and procedures. We looked around the home and saw some people's bedrooms, bathrooms, the kitchen and communal areas.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they felt safe, and everyone we spoke with said they did feel safe. Relatives we spoke with confirmed this too. One person said, "I am safe, they call the doctor if I need one." Another person said, "I am safe, staff look after me."

We found that risk assessments were in place, as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments. A personal care plan for each area was written using the results of the risk assessment, which described the actions staff were to take to reduce the possibility of harm and we saw that these were regularly reviewed to ensure people's needs were met.

Staff we spoke with during the inspection were aware of the different types of abuse and what would constitute poor practice. Not all staff we spoke with had undertaken training in safeguarding but were able to describe how they would recognise any signs of abuse or issues which would give them concerns. They were able to state what they would do and who they would report any concerns to. Staff said that they would feel confident to whistle-blow [telling someone] if they saw something they were concerned about. The manager was in the process of making sure all staff had updated training.

The management team had worked with other individuals and the local authority to safeguard and protect the welfare of people who used the service. Safeguarding incidents had been reported by either the service or by another agency. Incidents had been investigated and appropriate action taken.

We looked at the recruitment records for five members of staff. These showed that recruitment practices were thorough and included applications, interviews and references from previous employers. We saw evidence of application forms with gaps in employment suitably explained, interview notes, job descriptions and proof/ photographic proof of identification documents, in the staff files we reviewed. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. There was a system in place to check that nursing staff were registered with the Nursing and Midwifery Council (NMC). The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK. Monitoring nursing staff's registration should help to ensure people receive care and treatment from nursing staff who are required to meet national standards and abide by professional code of conduct. The manager said, "Staffing turn over is low to none, indicating a good service delivery and continuity of care for residents."

We asked people who used the service whether they thought there were enough staff on duty. One person said, "Staff are often short handed. They have too much to do" Another person said, "They do what they can." And "Staff have been changing." We looked at staff levels. At the time of our inspection 40 people lived at the service. The manager told us that they completed a Care Home Equation for Safe Staffing (CHESS) tool on a weekly and monthly basis and as people's needs changed, to calculate the number of care and nursing staff hours required throughout the day and night. The manager told us that they were currently discussing staffing levels with the regional manager as they felt at least one more member of staff was needed on a morning and possibly a 'twilight' staff member. They said that they recognised the importance of not just looking at occupancy and dependency levels when assessing staff numbers but also considering the environment of the home and how that impacts on the demand placed on staff resources. This meant that the service was considering some factors to determine sufficient numbers of suitable staff, to keep people safe and meet their needs.

One person told us they had rung the call bell for help to go to the toilet and a carer had come and told them that they would be back in 10 minutes. After 20 minutes they rang again and was told that the care worker had forgotten. The manager informed us they were looking into the answering of call bells as a matter of priority. We saw not all people had call bells. We questioned this and staff on the dementia unit told us that one man wrenches the cord out

Is the service safe?

and another is unable to use it. However we saw two people in the residential unit with call bells absent or out of reach. We discussed this with the manager who had the call bells in place the day after inspection.

We saw a record of all accidents and incidents. Accidents and incidents were monitored to try

and determine if there were any trends and if so a risk assessment with identified remedial actions would be put in place.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced such as fire equipment, lift and hoists. We saw that the water temperature of

showers, baths and hand wash basins in communal areas were taken and recorded on a weekly basis to make sure that they were within safe limits.

We looked at records to see if checks had been carried out on the fire alarm to ensure that it was in safe working order. We saw that fire alarms had been tested on a regular basis. Although we saw when the handyman was off sick or on annual leave, these tests did not take place. We discussed this with the manager who said they would make sure this did not happen again. We could not see any evidence of a recent fire drill. The manager told us they had one planned for September. Staff we spoke with said, "We had a fire drill about two weeks ago." A person who used the service said, "There was a fire drill last Friday." We could not see that these had been recorded.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and emergency lighting. Portable appliance testing (PAT) this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use was taking place at the time of our inspection. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

The service had an emergency and contingency plan, and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This meant that plans were in place to guide staff if there was an emergency.

We looked at the management of medicines. We saw people receive their medication at the time they needed them. We saw staff checked people's medication on the Medication Administration Record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. We saw medicine administration records (MAR) were on the whole complete. We saw some handwritten entries on MAR charts, hand-written MAR charts are produced only in exceptional circumstances and can only be created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used as per NICE guidelines 1.14.9. Although the information recorded was correct there were not always two signatures.

We saw some evidence of 'when required' (PRN) protocols in place. These provided guidance about how and when a PRN medicine would be administered. They were not in place for all PRN medicines. Medicines were stored securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines with a short a life once opened had the date of opening noted, this meant it remained safe and effective to use. Liquid medicines did have handwritten labels attached stating 'please write date opened,' although these bottles had been opened there was no date recorded. The service had a medicine key handover book, we saw that this was not completed daily.

We looked at the MAR charts for applying topical cream (TMAR). We found these were not specific enough in terms of instruction for example apply to affected area, but nothing was recorded to say where the affected area was.

One person received their medicines covertly (without their knowledge). We saw that a best interest meeting had taken place with the GP and next of kin, all information was recorded plus how to covertly administer and a regular review took place. The next of kin said, "My mother gets her medicines covertly and this was all discussed with me."

Requires Improvement

Is the service safe?

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss. We found there was an improvement with the management of medicines since our last inspection but there were still some minor issues to address.

We looked at the arrangements that were in place for ensuring cleanliness and infection control. We found that the main communal areas of the home were clean and free from unpleasant smells. Although one lounge on the dementia unit did have a malodour, which could have come from the blankets on the chairs. We discussed this with the manager the day after inspection that they had all been removed and washed.

Regular bed rail checks were conducted, the last of which was completed on 30 July 2015. It was identified that one room had space at the head of the bed and needed a cradle, we were unable to check whether this was in place as the person in this room was subject to barrier nursing on the day of our inspection. There was no record of any mattress checks to ensure any mattresses and profiling mattresses being used were in good condition and working order. The manager put a mattress audit in place immediately. One room we looked in had bare wood behind the toilet and under the sink. This is a potential infection control hazard as it would not be able to be properly cleaned. We found a communal bathroom to be messy, with rubbish bags, dirty linen skips, a blank care plan and a fork. We discussed this with the manger and the majority were removed by the end of the day although the laundry skips were still in place.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if they felt staff were well trained and knew what they were doing. Everyone we spoke with said they felt that staff were trained sufficiently to meet their needs. One person we spoke with said, "During bathing staff have to be careful with my leg and my head and they are." A relative we spoke with said, "My relative is PEG fed and I have confidence in the staff, I cannot fault them."

Staff showed they understood peoples needs. For example one staff member said, "If I talk to X on the dementia unit for too long they get agitated, so it is best to talk to them for short periods only."

We asked staff about their most recent training and one member of staff said "We get lots of training, I have just done safeguarding."

We asked to see the training chart and matching certificates. There were some gaps in training, the manager explained that a lot of training was taking place via e learning and there had been some issues with access for staff. The manager was in the process of rectifying this. A small number of staff had received training in the following areas, Mental Capacity Act, care profile, falls prevention, dementia and continence. We could not see evidence of competencies taking place. Again the manager had already recognised this and was putting this into practice. We saw evidence of what the induction training looked like. The manager said that staff on induction carry the books around with them to complete, therefore these were not available in files. The manager said, "The induction process allows new staff to work along side staff deemed competent, in order that they learn the expected processes of service."

The regional manager said they were shortly going to roll out the Care Certificate training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

One senior carer was about to commence on a Care Home Assistant Practitioner (CHAP) course. An assistant practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The assistant practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The assistant practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve."

We checked five staff records to verify that supervisions had been carried out two monthly and saw supervisions had been conducted for two staff, the other three staff had been recently appointed into their positions. The manager was unable to show us a copy of the supervisions plan for 2015, however they stated that they had identified issues and would be ensuring supervisions were undertaken every two months. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Regular supervision should help highlight any shortfalls in staff practice and identify the need for any additional training and support. Four staff had received an annual appraisal so far this year. The manager reassured us that they were going to ask the deputy manager to conduct appraisals for all staff within the next two months, as they knew the staff members.

We could not see records of regular staff meetings. The manager had only been in post two weeks and had recently held one. This meeting was a getting to know each other introductory meeting. The manager discussed their findings so far and gained feedback as to how staff were feeling.

We reviewed the daily staff handover which showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift. Information about people's health was shared, which meant that staff were kept up-to-date with the changing needs of people who lived there.

Mid-morning we observed people who used the service being offered two choices for lunch and choices for tea. Lunch was served at 12.30 but by 11.50 there were already three people who had been helped by staff into the downstairs dining room. We observed lunch on both the residential an on the dementia unit. Both dining rooms

Is the service effective?

were set attractively with tablecloths, napkins, condiments and a flower arrangement and there was a picture menu on display in the dementia unit. The food was well presented and hot and served direct from the kitchen. Staff checked the temperature of the food with a thermometer. We saw staff continuously serving hot and cold drinks. We saw that some people required pureed meals and we noticed that each part of the meal was pureed separately and placed on the plate in distinct portions to make the meal look more appetising and help people to distinguish what they were eating. There was some nice conversation between people on the tables. Staff interacted well with residents offering them choices and we heard people being asked if they had enough, did they want more and was it alright for you. People who needed assistance were treated respectfully. Where people required encouragement to eat their food staff provided this in a dignified manner, for example staff sat next to the person and interacted with them in a positive manner. This meant the risk of weight loss was minimised. People were asked for their choices and staff respected these. For example, people were asked what they would like to drink. In addition we saw staff sought consent to help people with their needs. The atmosphere was convivial and there was music playing in the background. Staff were also available to support people with tasks such as cutting their food up. In addition, when a relative came to visit at lunch time, a member of staff invited them to join the person for lunch.

People said that the food was good and that there was sufficient. Comments included 'she's a good cook' 'the food is great.' One person said, "The food is very good and I'm awkward at times."

We saw evidence of the Malnutrition Universal Screening Tool (MUST) risk assessment. MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. MUST was completed monthly. Where people were identified as being at risk of malnutrition, we saw that referrals had been made to the dietician for specialist advice. In addition the person's care file stated "X is on the new regime of continuous feed, PEG and pump in good working order, X started to gain weight. " And "X remains at very high risk of choking and aspiration". We also saw a copy of the enteral feeding regimen from the nutrition and dietetics department, advising the service to "continue recommended feeding regimen, continue to encourage " X to take recommended (food supplements), continue to monitor weight."

We spoke with the head chef who showed us the file where they stored the diet notifications for people. Kitchen notifications included, individualised diet, support, guidance, equipment, records we looked at included notification to the kitchen regarding food likes, dislikes and dietary needs. An example we found for a person stated "PEG tube only nil by mouth". This meant there was good communication between care and catering staff to support people's nutritional well-being. We also saw recommendations from the speech and language therapist (SALT) team which stated "we therefore agreed with [Person] that they could have a couple of teaspoons of yoghurt and some mashed potato and gravy, when they felt up to it." However, we were unable to see the diet notification forms for two people and the head chef reassured us they would check the file to ensure it contained all relevant forms for people living at the service.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Our observations showed staff took steps to gain people's verbal consent prior to care and treatment.

The care plans we reviewed were decision specific. One care plan stated "to assess whether X has capacity to retain information and make decisions, as in past refused their feeds which will put them at risk of malnutrition." It was deemed that the person had capacity and thus records of best interest decisions were not required When people had been assessed as being unable to make complex decisions there were records of meetings with the person's family, external health and social work professionals, and senior members of staff. This showed any decisions made on the person's behalf were done so after consideration of what would be in their best interests.

The Care Quality Commission is required by law to monitor and use the Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The manager was aware of their responsibilities in relation to DoLS and was up to date with changes in legislation. We saw the service acted within the code of practice for MCA and DoL's in making sure that the human rights of people who may lack mental capacity to take particular decisions were protected. The manager told us they had been working with relevant authorities to apply for DoLS for

Requires Improvement

Is the service effective?

people who lacked capacity to ensure they received the care and treatment they needed and there was no less restrictive way of achieving this. At the time of our inspection DoLS had been approved for three people who used the service.

Staff we spoke with had some understanding of DoLS, but needed extra training. We discussed this with the manager who again had already recognised this. One staff member said, “These matters were dealt with by senior staff.” They then gave an example of a person who was blind and has had a stroke but who was still smoking because it is their right to decide to continue to do so.

We saw records to confirm people had visited or had received visits from the healthcare professionals. For example records included details of appointments with and visits by health and social care professionals such as the General Practitioner (GP), dietician, speech therapy and the Specialist Nutrition Nurse. An example of an entry from the Specialist Nutrition Nurse stated “visited, discussed problems with ongoing chest infection and positioning in bed, advised staff to call practice for advice” and we duly saw that this had been actioned. One person received a visit from a tissue viability nurse on the day of the inspection which we were told was part of an ongoing treatment and care plan.

We saw people signed where they were able, to show their consent and involvement in their plan of care. If they were unable to sign a relative had signed for them.

We looked around the premises and found it to be nicely presented. The dementia unit had could do with more dementia friendly adaptations such as different coloured doors. Deliberate use of colours can help significantly. For example, a red plate on a white tablecloth is more easily visible than a white plate, and toilet seats are easier to see if they contrast with the colour of the toilet bowl and walls. Colour can also be used to highlight important objects and orientation points (eg the toilet door) and to camouflage objects that you do not want to emphasise (eg light switches or doors that the person doesn't need to use).

Good

Is the service caring?

Our findings

We asked people who used the service if they were happy and found the service to be caring. One person who said they had only been in the service for a week said, "I love it . Anything at all you want, it's there for you. The girls are good. I couldn't fault it." Another said '"They are good girls here. I have a joke with them." One person said, "There is the odd one who is not alright, but I take no notice." And another said "They are all good. I can't fault any of them." And another person told us "It's better than I ever thought. It's really great. There's nothing I can grouse about'. And another "It could not be better. No complaints. I'm happy. Nothing could be improved."

A relative we spoke with said "The staff are very friendly." Another relative said, "Some staff are wonderful." And another said "The staff are lovely. I can't fault the carers. The nursing staff are very good."

Staff we spoke with said, "We have a strong family atmosphere and we are close knit with people who live here and their families, its relaxing and a lot of fun, it's a happy atmosphere." And "This is the nicest place I have ever worked."

We saw staff treated people with dignity and respect. We asked staff how they ensured that people's dignity was maintained. One staff member said, "I always make sure they are covered with a towel so as not exposed." Another staff member said, "I make sure the door is closed and screens in place, I always make sure I have a female worker with me." People who used the service said they were treated respectfully, especially when bathed.

We observed during the visit that care staff were friendly and caring with people when supporting them. We spent time observing how staff supported people living at the home and found that staff were respectful in their approach, treating people with dignity and courtesy. We observed that people were asked what they wanted to do and staff listened. We observed staff explaining what they were doing, for example in relation to medication.

Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on doors and waiting before entering, ensuring people's privacy was respected. A relative of a person living with a dementia became upset as their relative was rather aggressive with them. We observed that staff were extremely caring and supportive to this relative. Another relative said that the staff not only looked after their loved one but also looked after them too.

The environment supported people's privacy and dignity. All bedrooms were for single occupancy. The majority of people had personalised their rooms and brought items of furniture, ornaments and pictures from home.

During the course of the day we saw that staff always gave people choice. For example we saw one staff member asked a person entering a lounge where they would like to sit.

At the time of the inspection those people who used the service did not require an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. The manager was arranging for information to be put on display about advocacy. There was information leaflets about Patient Advice and Liaison service (PALS). The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters.

Although the service had no one on end of life at present, we asked staff how they managed this in the past. One care worker we spoke with said, "At the end of peoples lives, care is stepped up with regular checks and care given to adequate hydration." They cited an example of a person who died whose relatives could not get there in time. Two carers sat with this person holding their hand. They said that the relatives were very grateful that their loved one had not died alone. They also said that sometimes relatives sleep next to their loved one overnight." A nurse we spoke with said, "I received a card from relatives of someone who had passed away, the words were so touching, I am keeping it forever."

A relative we spoke with said, "X has been ill, staff keep me informed and end of life care planning has been addressed."

Good

Is the service responsive?

Our findings

During our visit we reviewed the care records of four people. From the care plans we looked at it was clear that people's individual needs had been assessed before they moved to the home. Care plans provided information on people's individual care needs, support, actions and responsibilities, to ensure person-centred care, tailored to the individual, was provided to people who used the service. However we did find them confusing due to being difficult to navigate. The manager and regional manager said the Four Seasons were aware of this and new care records had been implemented and were due for roll out in the next week or so.

Examination of care plans showed they were person centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. We found that care records reflected personal preferences and wishes. This was helpful to ensure that care and support was delivered in the way the person wanted it to be. The care files did have a lot of information included but staff even found them confusing and some staff documented daily notes where monthly reviews were meant to be completed.

The manager said, "We carry out assessments and reviews for each resident, to ensure that we are delivering person centred care which is current." And "We encompass the individuals life history, preferences and choices, these are documented within their individual care plan, so all involved in care giving internally and externally, respect the individual's rights and choices."

One person who used the service said that they had recently been involved with reviewing their care plan with a district nurse. Relatives we spoke with said, "They discuss everything with me." And "They ring me if there is a problem."

We saw a a personal journal had been completed by the person who used the service or their relative. This is supportive for people with dementia who are receiving professional care in any setting. The journal is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It enables health and social care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs. It can therefore help to reduce distress for the person with dementia and their carer.

We saw evidence that the service used The Cornell Scale for Depression in Dementia (CSDD). This was designed for the assessment of depression in older people with dementia who can at least communicate basic needs. The CSDD differentiates between the diagnostic categories and severity of depression. Scores are determined by a combination of prior observation and two interviews: 20 minutes with the carer and 10 minutes with the person living with a dementia Depressive symptoms are suggested by a total score of 8 or more. A person with both dementia and depression will be struggling with two lots of difficulties. They may find it even harder to remember things and may be more confused or withdrawn. Depression may also worsen behavioural changes in people with dementia, causing aggression, problems sleeping or refusal to eat. In the later stages of dementia, depression tends to show itself in the form of depressive 'signs', such as tearfulness and weight loss. By carrying out the Cornell Scale assessment this showed that the service was making sure they were aware of signs of depression and could put a plan in place which may include more activities or regular one to one sessions.

We spoke with the activity coordinator on the day of inspection. The activity coordinator was a carer in the home for six years and had been the activities coordinator for the last three years. The manager told us that they worked 38/40 hours / week. However we were told that they worked as a carer at breakfast for five days a week and we also observed that mid-morning they were going round asking for people's meal choices. Lately they told us they had been more on care duties than on activities due to staffing levels, holidays and sickness.

The activity coordinator told us they had completed their level 2 in health care which was 'leisure based' and was now completing level 3 which is also activities based. They had also visited sister homes to see other activities coordinators at work. They said they spend Monday and Wednesdays on the downstairs Rose unit, Tuesdays and Thursdays on Tulip, the dementia unit and Fridays on the Lily unit. The coordinator said that they had tried different

Good

Is the service responsive?

models. For example covering the whole home each day but found that it was unmanageable. However for some events such as films, people from different units were sometimes brought together.

They explained that they do not have a budget for activities but raised money for the 'Residents' Fund through the summer fair, a sports day, raffles, tombola etc. People who used the service had occasional outings using a coach company but this depended on the goodwill of other care staff who have to use a day off to assist with trips. They do however take individual people to the local shops or library since the home is very close to these. There is also a pub where they can go. The home has a garden with a vegetable patch which is being renovated. People who used the service said they liked the coordinator. Staff we spoke with said, "They are the best activity coordinator we have ever had." Another staff member said, "The activity coordinator is amazing, I don't know where they get their ideas from."

One person who used the service sat in the foyer said, "I am bored a bit in here. " They said they had been in the home for nearly five years and was previously in another home where there were games leagues with inter-home teams.

They acknowledged that the staff were too busy but they would welcome more games and quizzes such as dominoes etc. They also said they would like to go out more too. We provided the manager with this information.

A regular activity programme was in place and we observed a music session on the morning of our inspection. This consisted of the coordinator getting out a keyboard which was their own property, in a small lounge where two people were asleep and one person was in a wheelchair. Another person was brought in who sat down and played the keyboard. The person in the wheelchair appeared to be engaged but the two people continued to doze.

We saw posters up in reception advertising an upcoming sports day for people who used the service, staff and relatives.

We looked at the home's complaint procedure, which informed people how, and who to make a complaint to and timescales for action. All complaints are logged onto the DATIX. We only saw evidence of one complaint from March 2015. People who used the service had no complaints, one person said, "No complaints, I am happy, nothing could be improved."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a manager who had been in place for only two weeks. They were starting the registration process with CQC.

At the inspection the manager told us of various audits and checks that were being carried out and provided evidence of these. These included audits of the environment, infection control, nutrition, catering, dining experience, medication and health and safety. This helped to ensure that the home was run in the best interest of people who used the service. These audits and checks were followed up with a small action plan which could be improved to add more detail such as who would be responsible for action and date to be completed by. The audits assured us the quality assurance system was effective because it continuously identified and promoted any areas for improvement.

The manager said, "On a daily basis we carry out a 'walkabout' audit on the iPad which identifies all areas within the home. The audit focuses on the first impressions of the home, documentation, staff feedback, engagement with residents and visitors in the home."

Although the manager had only been at the service for two weeks some people who used the service said they knew them.

Staff we spoke with said, "They [the manager] listen and I am impressed that we have already had a staff meeting." Another staff member said, "The new manager is very approachable, they will be good, we see eye to eye."

We asked what links the service had with the local community. The manager said they have numerous links such as local primary schools, churches, Roseworth library, K & L ponies, class act which is a volunteer music group, Kays clothes and Horse and Jockey pub.

We saw evidence of one meetings for people who used the service that had taken place this year. Topics discussed were mainly around laundry and call buzzers. There were some complaints that call buzzers were taking too long to answer. This was something the new manager was looking into.

We asked the manager how they gain feedback from people who used the service, relatives, visitors and staff. The manager said, "Firstly by chatting with different residents each day and asking them give feedback. This is done informally and in a friendly manner." And "We prefer face to face verbal feedback and this is on going with residents, relatives, visitors and staff."

The service also has an iPad feedback stand in reception, this can be completed by anyone living in the home, visiting the home or working in the home. The manager said, "Four Seasons use the iPad to gather views from all these groups on daily and weekly time frames. Once this information is gathered, the report is sent to the manager. The manager then responds accordingly and actions taken. Where needed, views are disseminated within the home, either on a 1:1 basis, group basis, staff meetings, supervision times and memo's. The views are also seen by the area manager and up to the board level. This is so as a company lessons can be learned and new processes put into place, if needed."

We asked the manager what had been their greatest achievement at the service. The manager said, "I have begun to bring stability within the home, empower nurses and senior carers to make decisions giving them more authority and support residents to feel secure with having a stable manager in place. However, this is only minor achievements in a short space of time. I aim to bring training and supervision up to date. Also looking at layout of the home and best ways to provide a high service."

We asked staff if the service had an open and hones culture, one staff member said, "It is open and honest, I have never encountered any problems. There is a positive feel from all staff about both jobs and residents." And "The home is very positive, we are a cheerful lot, everyone is happy."

We asked the manager how they promote the services visions and values. They said, "Within the home and company we use posters, team meetings, supervision sessions and one to one meetings with staff and residents/ relatives. The ROCK awards are a way to promote vision and values for staff, while involving residents in the award ceremony." ROCK award are recognition of care and kindness. We saw two staff have won this award so far this year, through being nominated by relatives and people who used the service.

We found the service to have good leadership and management.