Mr & Mrs M Covell

Summerleaze Residential Home

Inspection report

Summerleaze
79-81 Salterton Road
Exmouth
Devon
EX8 2EW

Tel: 01395279349
Website: www.summerleazecare.co.uk

Date of inspection visit:
14 February 2017
20 February 2017

Date of publication:
28 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 14 February 2017 and returned announced for a second day on 20 February 2017. Summerleaze Residential Home is a large detached Victorian house in the town of Exmouth. They provide care and accommodation for up to 31 people with all rooms having ensuite facilities. On the first day of the inspection there were 29 people staying at the service. One of these people was staying at the service for a short stay respite period.

We had previously carried out a comprehensive inspection of this service in August 2015. A breach of a legal requirement had been found at that inspection. The breach was because people were not protected from unsafe and unsuitable premises. In particular, we highlighted scald risks from the hot water supply and windows on the first floor which were not restricted to prevent vulnerable people from the risk of falling out. Following the inspection we were sent an action plan setting out the actions the provider was going to take. At this inspection we found action had been taken regarding these concerns and the requirement had been met.

The service has two registered managers at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. One of the registered managers was a director who had decided to take a step back reducing their role at the service. Therefore the second registered manager undertook the majority of the registered manager's role. They said they were supported by the second registered manager and responsible person who would step in when they were taking leave. The responsible person was aware of the additional pressures and responsibilities the registered manager had taken on. They were putting in place a care administrator role to complete care plans and reviews and senior care workers were being delegated additional roles. These included undertaking supervisions for staff in their teams to relieve the additional work load on the registered manager.

Everyone gave us positive feedback about the registered manager and said they were very visible at the service and undertook an active role. They promoted a strong caring and supportive approach to staff. They felt this was then the culture in which staff cared for people at the service.

People were supported to follow their interests and take part in social activities. There was a designated activity person who along with the management team recognised the importance of social events for people. During the inspection a new weekly newsletter was started to keep people informed.

Staff were able to anticipate people's needs and were respectful, discreet and appropriate in how they managed those needs. There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Staff were compassionate, treated people as individuals and with dignity and respect. Staff knew the people they supported, about their personal histories and daily preferences. Staff showed concern for people's wellbeing in a caring and meaningful way.

Where possible, people were involved in making decisions and planning their own care on a day to day basis. People said staff were caring and compassionate and treated everyone with dignity and respect at all times.

The management team and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) (2005). Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA for the majority of decisions. Following the inspection we received confirmation from the registered manager that best interest decisions had been formally recorded for all decisions made.

People were not always supported by sufficient staff to meet their needs promptly. This had been recognised by the management team and changes to the deployment of staff and additional staff were being implemented. Staff had the required recruitment checks in place and were trained and had the skills and knowledge to meet their needs. Staff had received an induction and were knowledgeable about the signs of abuse and how to report concerns.

People were supported to eat and drink enough and maintain a balanced diet. The management team had been working closely with people to make changes to the menu. They were also making changes to their catering team. People were seen to be enjoying the food they received during the inspection.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed.

The provider used a computerised care system to record the care people received. Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's needs and gave staff clear guidance about how to support them safely. They were personalised and people where able and their families had been involved in their development. Accidents and incidents were reported and action was taken to reduce the risks of recurrence.

People were referred promptly to health care services when required and received on-going healthcare support. Healthcare professionals were positive about the quality of care provided at the home and the commitment of the whole team to provide a good service.

The premises were well managed to keep people safe. The home was cleaned and decorated to a good standard and homely features made it welcoming. Systems were used to ensure the environment was kept clean and safe. There were emergency plans in place to protect people in the event of a fire or emergency.

The provider had a quality monitoring system at the service and were looking at ways they could improve their documentation. The registered manager actively sought the views of people, their relatives and staff. There was a complaints procedure in place and people were confident any concerns they raised would be looked into. The registered manager was reviewing and updating the homes policies to ensure they reflected current guidance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service has improved and is now Good.

Action had been taken to ensure people were protected from unsafe and unsuitable premises.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed

People were protected from abuse by staff who recognised signs of potential abuse and knew how to raise safeguarding concerns.

People's risks were assessed and action taken to reduce them as much as possible.

There were not always sufficient numbers of suitable staff on duty to keep people safe and meet their needs promptly. However this had been identified by the provider and action was being taken.

People were protected because recruitment procedures were thorough.

Accidents and incidents were reported and action taken to reduce the risks of recurrence.

Is the service effective?

Good

The service remains Good.

People were supported by staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decision making about people in their best interest. However these were not always formally recorded.

People were supported to maintain good health and access healthcare services. Staff recognised any deterioration in

people's health and sought medical advice appropriately.

People were supported to eat and drink enough and maintain a balanced diet.

Is the service caring?

Good

The service remains Good.

People gave us positive feedback. They said staff were compassionate, treated people as individuals and with dignity and respect. Staff knew the people they supported, about their personal histories and daily preferences.

Staff showed concern for people's wellbeing in a caring and meaningful way. They showed people compassion and had developed warm and caring relationships with them.

People were involved in making decisions and planning their own care on a day to day basis.

Is the service responsive?

Good

The service remains Good.

People received personalised care that was responsive to their needs.
Arrangements were in place for people to have their individual needs regularly assessed, recorded and reviewed.

People were supported to follow their interests and take part in social activities. The management team recognised the importance of social events for people.

People knew how to raise a concern or complaint, and said they felt comfortable doing so.

Is the service well-led?

Good

The service remains Good.

The management team were visible at the service and inspired staff to provide a quality service.

The management team and staff understood their responsibilities.

People and staff were actively involved in developing the service.

There was an audit program in place to monitor the quality of care provided and ensure the safe running of the service. The registered manager was looking to implement new documentation to capture the checks they had undertaken.

Summerleaze Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 20 February 2017, the first of these days was unannounced. The inspection was carried out by one adult social care inspector.

We reviewed information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed most of the people who lived at the service and received feedback from eight people who were able to tell us about their experiences. We also talked with a visiting hairdresser and received information from a relative after the inspection. We spoke with nine staff, which included senior care workers (team leaders), care staff, administrator and support staff, one of the registered managers and the responsible person.

We looked at the care provided to three people which included looking at their care records on the provider's computer system and looking at the care they received at the service. We reviewed the medicine records of four people on the computerised medicine system. We looked at four staff records and their training records. We looked at a range of records related to the running of the service. These included staff rotas, supervision and meeting minutes. Before the inspection we contacted health and social care professionals that supported people at the service to ask for their views about the service and received feedback from two.

Good

Is the service safe?

Our findings

People felt safe living at the home. People said they felt safe comments included when asked, "Yes everyone here is nice to me"; "oh yes" and "No one has ever been unkind to me here."

At our last inspection, there was a breach of regulation. This was because people were not protected from unsafe and unsuitable premises. In particular, we highlighted scald risks from the hot water supply and windows on the first floor which were not restricted to prevent vulnerable people from the risk of falling out. Following the inspection we were sent an action plan setting out the actions the provider was going to take. At this inspection we found action had been taken by the provider after our last inspection regarding these concerns and the requirement had been met. All first floor windows had restrictors in place and hot water outlets accessible to vulnerable adults had been fitted with thermostatic mixing valves (TMVs). These were set to ensure the water did not exceed the Health and Safety Executive (HSE) recommended temperatures of being no hotter than 44 °C should be discharged from outlets that may be accessible to vulnerable people. There were monthly checks undertaken to ensure window restrictors were not removed and that water temperatures did not exceed the recommended guidance.

There were sufficient staff to meet people's needs. However due to the deployment of staff at times this was not always promptly. Some people and staff felt there were certain times when there was not enough staff to meet everyone's needs promptly. This was in the morning and early evening. One person said, "It is not very good first thing in the morning and at suppertime could do with some more then." Another person, "They (staff) are very good, they are always there if you need them." Staff comments included, "It is extremely busy in the morning"; "It can be stressful at times especially mornings. It would be nice if someone else did breakfasts, it would cut down on bell calling" and "Mornings we need an extra one, evenings it would be good to have someone just before supper so not so rushed." We looked at the call bell audit undertaken by the responsible person for a randomly selected day in January and February 2017. The majority of people's call bells were responded to within three minutes. There were seven call bells which took staff longer than five minutes but these were responded to within ten minutes. Emergency alarms were responded to within thirty seconds. During our inspection we found that people's needs were being met in a timely way.

The staff rota showed there was a senior care worker and four care staff on duty each morning. In the afternoon there was a senior care worker and two care staff. On two days a week an additional care worker would stay on duty during the afternoon to support people who requested a bath at that time. At night there were two waking staff. The care staff were supported by the registered manager, a laundry person, two housekeepers, a cook, an administrator, a kitchen assistant and an activity person. The management team and staff undertook additional duties to cover gaps in the staffing schedule. The registered manager said they had recognised the pressures the early evening staff were under. In January 2017 they had discussed this with the responsible person and were looking to implement a twilight shift between four and eight o'clock to relieve the pressure. The responsible person said they had planned to implement the additional shift when they had unexpected bed vacancies which meant they needed to review the staff levels. However following discussions with staff this was planned to be started the week of our visit.

Before our last inspection the provider had recognised the morning staff level as an area of concern at the home. They had overlapped the night staff and day staff for one hour to have additional staff on duty to support people with their morning routines. At that time this had made a difference. However staff said with the people they were supporting this was a time where they were again stretched. This was because when the night staff finished their shift this left a senior and four care workers with two of these needing to undertake breakfast duties. This therefore left two staff to support people during this time. We discussed this with the registered manager and responsible person who confirmed they were taking action to redeploy care staff. They had started discussions with the catering staff to start their shifts earlier in order to take on the responsibility of delivering breakfast to people. This was planned to be started as soon as all the catering team had agreed and would free up care staff to undertake personal care for people. Following the inspection the registered manager made us aware they were recruiting additional care staff to undertake morning duties. This was because they could not come to an agreement with the catering staff. Their email said, "I will be implementing some extra help in the morning at breakfast time from current care staff as from Saturday 4 March."

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had undertaken training in safeguarding vulnerable adults. They had a clear understanding of what abuse was and how to report any concerns both internally and externally to outside agencies. Staff were confident any concerns would be addressed by the registered manager's.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff recorded accidents and incidents on the computerised system and the actions they had taken. The registered manager reviewed all accidents and incidents to ensure appropriate action had been taken and recorded their review on the computer system.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. A person admitted to the home had required oxygen. The registered manager had put in place a policy regarding the use of oxygen at the home to make staff aware. They had placed signage around the home to inform emergency services of the fire hazard posed by the oxygen being stored at the home.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. The person who required oxygen was a smoker and staff supported them to still smoke as that was their wish. The registered manager had discussed the concerns with the person of smoking with oxygen. A plan had been put into place that the oxygen would not be used for 15 minutes before the person went outside to have a cigarette.

People were protected because risks for each person were identified and managed. The provider used a computerised care system which included risk assessments for mobility, skin integrity and nutritional status. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. People identified as at an increased risk of falling had been assessed and appropriate actions were undertaken. For example the use of pressure mats and bedrails. People were protected against hazards such as falls, slips and trips. A falls assessment had been completed and action taken to minimise potential incidents. This included ensuring people's environments were free from clutter and safe footwear was being used.

People were kept safe from the risk of emergencies in the home. Individual evacuation risk assessments had been completed. These took into account the person's mental ability, physical ability, site familiarity and

mobility. The registered manager had placed this information in key areas around the home so it was accessible in the event of an emergency. They had also delegated responsibility to a staff member to ensure the information was kept up to date.

The service followed safe recruitment practices. Staff files included application forms, records of employment and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

Peoples' medicines were managed and administered safely. The provider used a medicine computerised system. This system was linked to the local pharmacist who dispensed medicines for this service. This meant that each month the pharmacist would transfer people's medicine administration requirements onto the computer system to guide staff. Staff recorded medicines they administered and topical creams they had applied onto the computer system. There was an alert system to flag up to staff and the management if a medicine or topical cream had been forgotten so people would have their medicines as prescribed.

All staff administering medicines had received medicine training. There was a designated senior care worker who undertook the lead regarding medicine management. They were working with the registered managers to develop competency assessments for all staff administering medicines.

Some people were able to self-administer their medicines with the support from staff. The staff had completed an assessment to assess what support the person would need to be able to self-administer their own medicines. They undertook regular audits and checks with these people to ensure they were taking their medicines as required.

Medicines were managed, stored, given to people as prescribed and disposed of safely. One person said, "They (medicines) are given safely, they (staff) are very careful with those, they know what they are doing with those." Another said, "They came in this morning and gave me my medication, very good." On the computer system people's Medicine administration records (MAR) were accurately completed and there was a current photograph of the person and indicated if the person had any known adverse reactions to medicines. There were simple protocols in place to guide staff when it was appropriate to use 'when required' medicines. The majority of people's medicines were stored in lockable cabinets in their rooms. Other's being held in a medicine trolley which was located in the dining room cupboard which was used at lunchtime and supper. Medicines which required refrigeration were stored at the recommended temperature and staff were knowledgeable about the procedure when the fridge temperature was outside of the recommended range.

On 2 February 2017 a pharmacist had visited the service and completed a medicines check. They had raised a few minor concerns regarding the management of people's medicines at the service. These related to the need for a blood sugar protocol for one person, a more up to date pharmaceutical reference book for staff to have current information available and a thermometer in the medicine trolley to monitor the temperature of medicines store there. Staff were taking action to address these concerns. There was a program of continuous auditing of medicines at the service undertaken.

The environment was safe and secure for people who used the service and staff. A new designated maintenance person had just been employed to oversee the maintenance at the service. Their predecessor had and they would take on the responsibility of regular checks of the service which included checking water temperatures, window restrictors radiator covers were in place and fire checks. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance.

Fire checks and drills were carried out and regular testing of fire and electrical equipment. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. There was a designated staff member to undertake laundry duties each day of the week. The laundry was well managed and had adequate chemicals and processes to ensure the lint filters were cleaned regularly. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Good

Is the service effective?

Our findings

People received care and support from staff that received training and support on how to undertake their role safely and effectively. The mandatory training staff completed included, fire safety, first aid, Control of Substances Hazardous to Health (COSHH), health and safety, manual handling, food hygiene, infection control, deprivation of liberties safeguards (DoLS) and safeguarding vulnerable adults. Two staff told us they had been supported at the service to complete their higher qualification in management. The administrator had been delegated responsibility to oversee that staff completed the required training. The registered manager said, where staff had not found time to complete the workbooks they had been allocated, they would be scheduled on the rota at the end of their shifts to allocate time for them to complete while at work. One person said, "Staff are very good, they know what they are doing."

Staff were positive about the training they received. One care worker commented, "We do training on the job and are given booklets to complete which are quite good." A health professional said, "On the whole they are knowledgeable regarding patient needs."

New staff were supported to complete an in house induction checklist before working on their own. The registered manager had not used the Care Certificate' programme which had been introduced in April 2015 as national training in best practice. They said most new staff had previously worked in care or had a care qualification. They said any new staff that did not have these were started on a health and social care qualification when they started at the service. They also undertook the provider's mandatory training and induction checklist. A staff member who had recently completed their inductions said, "The girls are really helpful especially (senior care worker). I did shadow shifts for two weeks which I felt was enough."

People were supported by staff who had supervisions (one to one meetings). The registered manager said these had not been as regular as they would have liked them to be. They had made the decision to delegate supervision responsibilities to senior care staff who line managed different teams. The registered manager would continue to undertake senior staff supervisions and staff annual appraisals themselves. Staff told us supervisions enabled them to discuss any training needs or concerns they had. Staff told us they had been supported by the registered manager. One staff said, "(Registered manager) is very helpful, really good if you need to ask anything I can go to her." Another said, "I can see (registered manager) at any time."

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided when they first came to the service. The provider used closed circuit television (CCTV) in communal areas of the home and had sought agreement from people at the home but this had not always been recorded. New people coming into the home were made aware of the use of CCTV as part of their admission to the home. The registered manager was looking to formalise this for people already at the service and on the admission process to demonstrate this had always happened.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take

particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home was meeting these requirements. The registered manager had identified one person who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

The registered manager had a clear understanding about the principles of the MCA. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions. Staff had completed capacity assessments for people and considered people's capacity to make particular decisions. A best interest decision had been undertaken regarding a person smoking in the front garden. It had been assessed following an incident that it would be in the person's best interest to use the back garden when smoking which was more secure and would put them at less risk. However for other decisions it was not always clear how they had been made and who had been involved in the decision making process. For example the use of bedrails and pressure mats. The registered manager said they would review all decisions made and ensure all of the information required was in place. Following the inspection we received confirmation from the registered manager these had been completed.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. There was one main meal choice each lunch time with alternatives available if people chose. We discussed with the registered manager that people were not aware of the lunchtime meal choice until they went to the dining room where menus were displayed on the tables. The registered manager said they would look at sending menus to people each week so they were informed in advance.

The registered manager had been working with people to develop the menu at the home. They had made several changes in response to people's wishes. This included adding fried egg sandwiches and curries. The registered manager said some people hadn't liked the curries so on those days an alternative was offered. They also said that liver and bacon had not been a success so this had been removed from the menu. There had been concern raised by a person using the service, with the management team about the food at the service which had been listened to. Changes had been made to the catering team and a previous cook was re-joining the team.

We observed a lunchtime meal in the dining room with 17 people enjoying their lunch with refreshments of their choosing. Others chose to have their meals in their rooms or the lounge. We spoke with people during their lunch who all said they were happy with their meal, with one person saying, "They only problem is there is too much."

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A health professional said, "They are very engaging, contact us promptly and appropriately, even having discussions prior to hospital discharge if care needs have changed for long standing patients and asking advise if needs have changed regarding pressure area care equipment etc. They put in all equipment that is asked of them, and they follow given advice."

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people. People were seen positively interacting with staff, chatting, laughing and singing. People said they were happy at the home. One person commented, "You wouldn't find anything better anywhere else. I am settled here." Another said, " I cannot praise the place enough. It is a genuine care home, they care about everyone here."

A relative said, "We are always kept informed of any changes to his care or medication and the staff without exception are in my opinion the best there is."

Staff said they felt the care was good at the service. Comments included, "The rooms are lovely, and standards are very high. I feel they (people) are really well looked after here. I enjoy my work and feel I am giving something back": "yes lovely home, clean tidy, well run. It is just the staff levels" and "It is lovely here they are all well looked after": "the standard is really good here, residents are really well looked after" and "we are like an extended family to the clients and their families."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. While we were with one person a staff member knocked on the bedroom door before entering and waited to gain consent before entering. Staff gave examples of how they maintained people's dignity and respect. One care worker commented, "I always ask them if it alright to wash them and always wrap a towel around them and ask if everything is alright."

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. The atmosphere at the home was calm and homely. During lunch staff were responsive to people's needs. They offered assistance where required and ensured people had everything they needed.

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in and the clothes they wore. We observed a care worker supporting a person to their room. They were very kind in their approach did not rush the person and throughout asked the person how they were feeling, had they slept well did she want to take a rest.

Staff described ways in which they tried to encourage people's independence such as dressing themselves with minimum support. Staff said they knew people's preferred routines, such as who liked to get up early and who liked to stay in bed. They ensured people were given a choice of where they wished to spend their time. One care worker said, "I do what they want at the time, if they say they don't want to get up I leave them and go back later."

There were numerous messages of thanks which had recently been sent to the registered manager and staff. These included, "I will always recommend Summerleaze and all the staff to anybody who is looking for somewhere for themselves or their relative"; "Your kindness has been outstanding, thank you for looking after (person) so well"; "Thank you all again for making mum's final years so happy and comfortable"; "Many thanks for your kindness" and "Thank you so much for all your help and support."

A relative told us in an email about their relatives experience coming into Summerleaze. They explained that originally it had only been for a short respite period and how quickly they started socialising and taking part in the homes routines. The email stated, "The staff couldn't have made him feel more settled instantly… my dad had decided instantly that Summerleaze was his home. I visited him on the morning of his second day at Summerleaze he wasn't in his room, to my amazement he had walked to the dining room, had breakfast and then proceeded to join the other residents in an exercise session. Such is the care my dad received, a level of care that stayed constant."

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors were made to feel welcome when they came to the home. A person said, "Visitors can come and see me anytime." A relative said, "We as his relatives are always made to feel welcome whatever the time of day and no request was ever a problem." People's rooms were personalised with their personal possessions, photographs and furniture. The home was spacious and allowed people to spend time on their own if they wished. Although the majority of people chose not to use the quiet areas of the home and mainly congregated in the television lounge.

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. The registered manager had discussed and agreed with people and appropriate relatives the need to have their Treatment Escalation Plan (TEP) held in their rooms. The TEP is a document which is completed by a doctor regarding what has been decided for that individual in the event of them being unwell and experiencing a cardiac arrest. The registered manager said they wanted it to be readily accessible to staff in the event of an emergency. The registered manager had been working with people's GPs to ensure the TEP's reflected people's wishes.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were recorded on the provider's new computerised care system. The care plans were personalised and detailed daily routines specific to each person. Speaking with staff they had a clear understanding of people's needs and the support they required. For example one person was on the whole independent but when they had an infection they needed a higher level of support which needed to be offered in a sensitive manner. Speaking with the person, they were happy with the care they received and said they liked to be left to do things themselves which reflected what care staff had said.

The service was responsive to people's needs because people's care and support was well planned and delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop comprehensive care plans. Care plans were recorded on the providers computerised system. One person told us about their admission into the home. Their comments included, "I was made to feel very welcome when I arrived, and nothing was too much trouble. I do the activities. I am happy in my room watching my television that is me. They respect that."

Since our last inspection the provider had decided to change the computer system they had been using and implement a new one. This meant a lot of work had taken place to transfer information. The registered manager said there was still more information she wanted to gather and add. They said with the new care administrator in place that would be something they would be prioritising. Staff could access people's information using a unique identification access code. Care workers could record tasks completed and relevant information about people. For example checks undertaken, care and support given. The registered manager said they kept reminding staff to put notes in at the point of care.

People's computer records included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. Care plans and risk assessments were completed and up to date. Risk assessments included an assessment of nutritional needs, mobility, falls and skin integrity. As part of the new care administrator's role, people and their families were being given the opportunity to be involved in reviewing their care plans.

We found that one person who was at the service for a short respite visit had no information recorded on the computerised system. However staff did have access to a handwritten document completed by the registered manager to make them aware of the person's needs. We discussed this with the registered manager who explained that it was quite a lengthy process to input information onto the computer at first for each person. On the second day of our visit they had put in place a new paper system to capture all of people's information who were at the service for a short respite stay. They explained that this contained all of the same risk assessments and details as the computer system and that all senior care staff could

complete it when a new person came to the home. This meant there was a system to ensure people receiving respite support had the support they required.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to do. There was a designated member of staff to oversee activities provision at the home. They undertook one to one visits with people who chose or were unable to leave their rooms due to a health need. They were implementing a weekly newsletter to keep people informed about what was happening at the home and activities available. On the second day we were shown the first newsletter which included a seasonal poem, information about new staff and an activity schedule which included, arts and crafts, quizzes, bingo, and hand massage and one to one sessions. People were also reminded that the staff team would welcome any feedback and would take on board any recommendations and suggestions. The newsletter also reflected on activities which had been carried out to celebrate Valentine's day. This included art work people had completed of cut out and painted hearts which were displayed in the dining area of the home. People had also enjoyed a valentine's quiz. A not for profit shop was run for people to be able to purchase small items. A designated staff member went around twice a week so people could buy as they chose and make suggestions which would be added to the shop.

People had access to the provider's complaints policy. The complaints procedure identified outside agencies people could contact. People said they would feel happy to raise a concern and knew how to. One person said, "If I had a concern they would soon hear my views." Another said, "I would tell (registered manager) she is very good."

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been no complaints received by the registered managers since our last inspection. A concern had been raised to the Care Quality Commission (CQC) regarding the meals at the home, leadership and staff issues involving the laundry. We had raised these with the registered manager who had investigated the concerns thoroughly and taken action to try and resolve the concerns identified. This included changes to the catering team and meals.

Good

Is the service well-led?

Our findings

There were two registered managers at the service and one of these was a director of the service. Since our last inspection the registered manager who was a director had needed to reduce their input at the service and had handed over more responsibilities to the other registered manager. We only met this registered manager during our visits. They said their workload had increased but assured us the other registered manger was always available if required and took responsibility when they were on leave. The responsible person was aware of the additional pressures and responsibilities the registered manager had taken on. They were working with them to develop a new role and delegate some responsibilities to senior staff. This included the development of a care administrator role to complete care plans and reviews and senior care workers undertaking supervisions and one being an infection control champion. Health professionals were positive about the leadership at the home. One commented, "We feel the service is well led."

The staff had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The registered manager and staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care. The registered manager said their ethos was that they liked staff to be open and honest. She said, "I say if you have made a mistake be honest and then we can deal with it."

The provider's website said, "Our care home in Exmouth provides residential care accommodation and respite care for older people, who enjoy their independence." This was demonstrated at the service with people using the outside areas of the home and undertaking outings with family members during our visit as they chose. People had telephones in their rooms to enable them to stay in contact with family and friends and make arrangements as they chose.

There were accident and incident reporting systems in place at the service. The registered manager monitored and acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.

People were empowered to contribute to improve the service. Residents meetings had been held at the home the last one being in June 2016. At that meeting they discussed ideas for changing the menu at the home. However the registered manager was very active in the home and spoke with most people each day. During our visits people were seen going to the registered manager's office for a chat. The registered manager said they were planning to hold a residents meeting every four months. The registered managers were in the process of sending out surveys to people to ask their views of the service.

People's experience of care was monitored through the registered manager being very active within the service. They spoke with people each day and also undertook duties which meant they supported people with their care needs.

The provider had a quality monitoring system in place. This included a monthly medicine audit. The registered managers, responsible person and maintenance person undertook daily environmental checks which they did not formally record. The registered manager said they primarily completed people's care plans, assessments and reviews so an audit was not necessary. The registered manager was looking at the documents offered by the local authority 'quality assurance and improvement team to be able to formally record the checks they were undertaking. The registered manager was also reviewing and updating the homes policies to ensure they reflected current guidance.

Staff meetings were held every month and more regularly if required. Records of these meetings showed staff were able to express their views, ideas and concerns. The record of the last staff meeting in January 2017 showed staff discussed kitchen matters, laundry, people's care and working practices. Staff were positive about the meetings. One care worker said, "We have staff meetings often. There is an agenda where we can add things we want to discuss."

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared any issues brought forward. This meant staff were kept up to date about people's changing needs and risks.

In between the two days of our inspection the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored five with the highest rating being five, which confirmed good standards and record keeping in relation to food hygiene had been maintained. Where concerns had been identified regarding the need to update the safer food better business document and an antibacterial spray in use which was not recommended. The registered manager had taken immediate action regarding these areas.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested.