Pinnacle Care Ltd

Sedlescombe Park

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

We inspected this service on 19 January 2016. The inspection was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service provides accommodation and personal care for up to 24 older people who are living with dementia. Eighteen people were living at the home on the day of our inspection.

There were policies and procedures to minimise risks to people's safety. Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's health and social needs. The registered manager checked staff's suitability to deliver care and support during the recruitment process. The premises were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. Staff received training and support that ensured people's needs were met effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No one was subject to a DoLS at the time of our inspection, but the registered manager had sought advice from the local authority head of DoLS. The registered manager was in the process of assessing people's care plans to make sure they had the proper authority to deprive a person of their liberty if it was in their best interests. For people with complex needs, records showed that their representatives or families and other health professionals were involved in making decisions in their best interests.

People were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs, which minimised risks to their nutrition.

People were cared for by kind and compassionate staff who knew their individual preferences for care and their likes and dislikes. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health.

People and their representatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed.

The quality monitoring system included regular reviews of people's care plans and checks on medicines management and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence. Staff were guided and supported in their practice by a registered manager they liked and respected.

Improvements were required in assessing risks to the premises to ensure the building and equipment were maintained to a standard that supported best infection prevention and control practice.

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 was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who relevant training and skills. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by encouraging them to make their own decisions.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes. Staff supported and encouraged people to take an interest in their surroundings and their community. The registered manager took action to resolve complaints to the complainant's satisfaction.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The provider's risk assessments of the premises had not identified some issues and equipment that required replacement or refurbishment. People, their relatives, staff and other health professionals were encouraged to share their opinions about the quality of the service. The registered manager and staff and checked that

people received the care and support they needed.

Sedlescombe Park

Detailed findings

Background to this inspection

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

The inspection took place on 19 January 2016 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of residential care service.

The provider completed 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.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 12 people who lived at the home and a relative. We spoke with the registered manager, a cook and three care staff. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support

appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us the service was good and they felt safe. One person told us, "I feel I can trust everyone here." A relative told us they were confident that that their relation was safe at the home, because care staff knew immediately when their relation went into another room independently. A relative told us, "[Name] is happier and safer than he's been for years." We saw that people were relaxed with care staff and were reassured by their voices when they became agitated, which showed they trusted care staff.

The provider's policy and procedures for safeguarding and whistleblowing were known and understood by the registered manager and care staff. Care staff were trained in safeguarding and knew the steps they should take if they had any concerns. A member of care staff told us, "I would challenge any poor practice, such as poor moving and handling techniques or not being nice to people. I have never needed to report anything." Care staff knew that any allegations of abuse would be reported to the local safeguarding authority. The registered manager had not needed to make any referrals to the local safeguarding team.

The provider's policy for managing risks included assessments of people's individual risks. In the three care plans we looked at, the registered manager assessed risks to people's health and wellbeing. Where risks were identified, people's care plans described how care staff should minimise the identified risks. The registered manager checked risks to people's mobility, communication and nutrition and described the equipment needed and the actions care staff should take to support people safely. Care staff were knowledgeable about people's individual risks and how to support them safely. We saw care staff supporting one person using the hoist, as described in their care plan. Another person who lived at the home told us care staff were, "Very efficient." Care plans showed people's risk assessments were regularly reviewed and updated.

Records showed care staff recorded incidents, accidents and falls in people's daily records and kept an on-going log for analysis. The registered manager analysed falls by the person, the location, time, outcome and action taken. A recent falls analysis identified that one person had fallen several times recently, so the registered manager had arranged for their GP to visit to check whether an underlying change in their health had caused the falls. Records showed a previous falls analysis had identified several falls had occurred early in the morning in the lounge. The registered manager had re-allocated staff to ensure a member of care staff was in the lounge from 7:30 in the morning onwards, to minimise the risk of a re-occurrence.

The provider's policy for managing risk included regular risk assessments of the premises and emergency plans for untoward incidents. Care staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency. The registered manager told us they had recently been re-inspected by the local Fire and Rescue Service, who were satisfied their recommended actions had been completed by the provider. The provider's risk assessments identified hazards, the preventative measures in place and actions to take. Actions included regular safety checks and maintenance agreements for essential services and equipment, such as the gas and water supplies, the lift and mobility aids. A member of care staff told us, "Urgent issues, plumbing, electrical, are attended to straight away. There are emergency contact numbers for the lift and hoist."

People told us there were enough care staff to support them with their needs. A relative told us there were always care staff around when they visited. The registered manager used a dependency needs analysis tool to decide how many care staff were needed on each shift. The analysis included a rating of low, medium or high needs per person, the registered manager's observations of care and support delivered and included a weighting for the size and layout of the building. On the day of our inspection, we saw the analysis was effective and there were enough care staff to support everyone according to their physical and emotional needs. Care staff told us staffing levels were appropriate and they had enough time to support everyone according to their needs. A member of care staff told us, "Now we have four care staff on all day, it makes a difference. We have time to talk, time to engage people."

Care staff were recruited safely and the registered manager checked that care staff were of good character before they started working at the home. The registered manager showed us records of the checks they made of care staff's suitability for the role before they started working at the home. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Care staff who were educated or trained abroad also completed literacy and numeracy tests, to demonstrate their ability to communicate effectively and keep accurate records.

A team leader showed us how they managed and administered medicines safely. Medicines were kept in a locked room and care staff told us, "Only trained staff administer medicines and there is a named member of staff responsible on each shift." A member of care staff told us, "I had in-house medicines training and with the pharmacist and was observed to check my competency twice."

Medicines were delivered from the pharmacy in colour coded blister packs, which were marked with the name of the person, the time of day they should be administered and a photo of the person to confirm their identity. Medicines delivered in boxes and liquid form were kept in a locked cupboard and liquids were marked with the date the medicine was first opened, to ensure medicines were administered or disposed of within their expiry date.

The medicines administration records (MAR) we looked at were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Care staff recorded when medicines were not administered and the reason why not. For example, if a person declined to take them or the GP changed their prescription. When creams were prescribed, body maps were included and colour coded to show exactly where each cream should be applied.

Care staff received guidance to ensure people's medicines were administered appropriately. One person whose MAR sheets we looked at was prescribed three different pain relief medicines to be taken 'as required'. The registered manager had written protocols for each medicine which explained how and when care staff should offer pain relief. The protocols described how care staff should monitor the person for signs of pain, such as showing signs of agitation, and the circumstances for reporting the GP's advice, such as persistent or never requesting pain relief and if any side effects were noted.

Good

Is the service effective?

Our findings

People told us the care staff were very good and supported them according to their needs and abilities. One relative told us they thought the service was very effective, because they had noticed improvements in their relation's moods, appetites and appearance since they moved into the home. We saw care staff knew people well and supported them appropriately with their physical and social needs.

People received care from care staff who had the skills and knowledge to meet their needs effectively. New care staff had an induction programme which included training and shadowing experienced staff. A member of care staff told us, "I have been shadowed by new staff. I showed and explained everything we do as we went along. Then I teamed up with them on their first functional shift. They took the lead and I mentored them."

The registered manager told us that all new care staff now completed the Care Certificate as part of their induction programme. Two care staff had completed the programme and two were in progress. The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of care staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

Care staff told us their training was valuable because they acquired practical skills and new insights and awareness of how to support people, particularly people who lived with dementia. Records showed that care staff received training that was appropriate to people's needs, such as, mental health and dementia awareness, falls prevention and daily record writing.

Care staff told us they felt supported in their practice and were encouraged to consider their own professional development. Care staff told us they had regular one- to one meetings with the registered manager and discussions included how they felt about their work how well the team worked together. Care staff told us, "I have a one to one every two to three months, but the manager always finds time to have a chat in between if you need one" and "We discuss career options at one to one meetings. There are lots of opportunities for progression."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care staff understood the requirements of the MCA. Care staff asked people how they wanted to be cared for and supported before they provided care. A member of care staff told us, "I have had MCA training. It's about your approach to people. We have strategies around consent, to prompt and encourage, not tell." People's care plans included mental capacity assessments for specific decisions and explained which decisions care staff should make in people's best interests if they were unable to decide at the time. For example, the three care plans we looked at instructed care staff to obtain other health professionals' advice if the person became unwell or if their health needs changed. A member of care staff told us, "Most have family to support their decision making. [Name] has a solicitor too."

The registered manager understood their responsibility to comply with the requirements of the Act. One person who lacked the capacity to give their consent had rails on their bed at night, because this decision had been made in their best interests while they were in hospital. The registered manager assured us they would review the person's capacity to make a decision about this safety measure and if the person was assessed as lacking capacity, they would document when and why they had taken the decision in their best interests. The registered manager told us they were 'in discussion' with the local supervisory body about submitting DoLS applications, because no-one currently went out of the home independently. They assured us they would submit applications based on the local authority's advice and notify us when any applications were approved.

People told us the food was very good and they always had a choice. One person told us, "The food is fabulous here." At lunch time care staff encouraged people to eat in the dining room, which gave them a reason to change position and an opportunity to socialise. For people who preferred to eat in the lounge, care staff brought tables, cutlery and drinks to their chair. Care staff asked people what they would like to drink and which meal they would like before serving them. Care staff showed both meals to those people who were not able to communicate verbally, which promoted independent decision making.

Most people ate independently, but some people needed assistance from care staff and there were enough to assist people one-to-one. Care staff sat beside those people, verbally encouraging them, or by placing cutlery in their hand. The meal was unhurried and care staff gave people time to savour and enjoy their meal. Several care staff sat and ate their lunch with people, which enabled them to assist, encourage and to observe how well people ate. People who did not eat well were offered milky drinks to provide additional nutrition.

The cook told us the menu was suggested by the provider to offer a nutritionally balanced diet and daily choice, but they were able to adapt the menu according to people's preferences. Care plans included a list of people's food preferences, needs and allergies, to ensure people were supported to maintain a diet that met their needs. Care staff knew people's dietary needs, for example, who needed a soft diet and who only ate finger foods. People were regularly weighed and care staff recorded whether people ate well so they could monitor their appetites and nutritional intake. People who were at risk of poor nutrition were referred to other health professionals, such as dieticians and speech and language therapists. Care staff recorded how they followed the health professionals' advice and monitored the actual volume of fluids and amount of food people ate.

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People were supported to maintain their health. A relative told us their relation saw their GP, the district nurse and a chiropodist when they needed to. Records showed that care staff kept a record of other health professionals' visits and their advice, and shared information at handover. A member of care staff told us, "You can see if people are not well, their faces, their moves, knowing them well. I can call a GP or tell the team leader." Care staff knew who was currently under the care of the doctor, district nurse or dietician and the advice they had given, which meant they understood people's healthcare needs.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person told us, "The workers are very patient and kind to me. They encourage me but let me go at my pace." A relative told us, "They have a wonderful way of persuading him, in the best possible way to do things he'd got out of the habit of doing at home."

Most people were not able to tell us how they were involved in agreeing their care plan, because of their complex needs. However, the care plans recorded how people and their representatives had been asked how they would like to be cared for and supported. A relative told us they had been involved in care plan discussions, which enabled them to share information about their relation's habits and preferred routines. Care plans included a section entitled, "All about me", which included the person's religion, culture, family and significant events. Care staff told us this helped them to understand the person and to get to know them as an individual and to understand their anxieties and behaviours.

We saw care staff understood people and supported them with kindness and compassion. Care staff understood that some people were unable to communicate verbally, but they understood people's needs through their body language and facial expression. A member of care staff explained the actions they took when one person became agitated. We saw the action care staff took reduced the person's agitation, because they understood the cause. We observed another person needed continuous verbal reassurance that 'everything was alright' and care staff offered the reassurance with patience and understanding.

Care staff recognised and respected people's diverse needs, for example how and where they liked to spend their time. People told us, "Care staff respect that there are times I want to be left alone" and "Care staff make me feel part of things. They don't just take over, but they respect what I can do." Care staff told us they operated a 'best friends' policy, which meant they were the named main contact person for people's families and looked after people's wardrobes, clothes and toiletries. Care staff told us this policy worked well as it made sure everyone had a friend to represent them, to get to know them well and make sure every need was met. One person told us care staff supported them to go shopping for new clothes.

A member of care staff told us they understood equality and diversity as, 'not imprinting your own beliefs on others', which helped them to actively promote people's right to make 'different' choices. They explained this right included people's preferences about the gender of care staff that supported them and their religious beliefs. The member of care staff told us, "[Name] does not want to attend religious services, so I support them to go to the other lounge when religious services take place" and "I know there are many religions and would find out about the different rites and traditions if I needed to."

We saw care staff respected people's privacy and promoted their dignity. For example, care staff knocked on people's doors before entering and spoke discretely when offering personal care. Care plans included information about people's preferences for physical and emotional privacy, which ensured care staff knew how to engage with each individual. Care staff kept people's personal information and records in a locked cabinet so only staff could access them.

One person told us, "My [Family] can come any time they like. Staff all know her by name and she's made very welcome and is offered a cup of tea." A relative told us they felt welcome to visit at any time.

Good

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted. They told us care staff understood them and knew their likes, dislikes and preferences, because they were involved in planning their care. A relative told us, "What is good about this place is that they listen to him, and me, and therefore he feels involved in his own care." They told us they were updated about their relation's progress each time they visited.

Care plans recorded people's likes, dislikes, preferences, hobbies and interests. Care staff told us these details helped them to understand the person and how they might respond to different approaches. A relative told us their relation had 'improved' since they moved to the home, because care staff knew how to engage with and respond to them. They told us their relation was more motivated and took more interest in 'life' than they had previously.

Care staff knew how people liked to spend their time and encouraged people to maintain their interests. A member of care staff told us that one person liked to be involved in household tasks. We saw this person putting cutlery and glasses on the dining tables just before lunch, which supported them to maintain a sense of purpose and independence.

The registered manager had appointed a 'dementia champion', to support care staff to better understand the impact of dementia on people's abilities and to develop strategies and techniques to engage people who lived with dementia. We saw care staff spent time encouraging people to take an interest in their surroundings and to take part in social pastimes. During the morning, some people played a game which promoted exercise and hand-eye co-ordination. People who played the game chatted to each other and to care staff, comparing their abilities. Some people were content and relaxed watching the activity in the room.

In the second lounge care staff offered people a hand massage and shared memories with one person by looking through their photo album with them. Everyone we saw was engaged and involved according to their abilities and preferences. Later in the day we heard two people, who did not communicate well verbally, singing with the encouragement of care staff.

People were encouraged and supported to celebrate significant events in their lives. The cook showed us the 'birthday list' and told us, "People get lots of treats. This is to remind me to make cakes and we have a 50th anniversary and 100th birthday to celebrate." There were photos of people celebrating previous events in the hallway. Items of interest, such as cuttings from old newspapers, vintage black and white photos of the local town and jewellery, hats and scarves were displayed at various places in the home to promote memories and reminiscence.

A member of care staff told us, "We keep daily notes and body maps if needed, and report any changes to the team leaders. Seniors review the care plans." Daily records included information about people's moods, appetites, whether anything was 'unusual' and if visits from other health professionals were booked or had

taken place. Care plans and risks assessments were regularly reviewed and updated when people's needs changed.

One person told us, "I could tell any of the staff, especially the manager, if I had any complaints and they would be dealt with." A member of care staff told us, "People are told about the complaints policy at admission and there is an agreed procedure with a timeline to respond. There is a complaints log for anyone to write in, or they can speak to anyone in private." The registered manager showed us the complaints log and the actions taken to resolve them. Records showed complaints were resolved promptly to the complainants' satisfaction. The registered manager discussed complaints at team meetings to make sure care staff understood the causes and actions to take to minimise the risk of similar complaints in the future.

Requires Improvement

Is the service well-led?

Our findings

The people we spoke with were happy with the quality of the service. One person told us, "I honestly feel the staff do try their best for me. They have my best interest at heart. It's wonderful, really." A relative told us, "I wouldn't say a bad thing about them here."

One person told us, "It's very open and honest here." The provider's quality monitoring system included an annual survey to ask people, staff and other health professionals for their views about the service. The most recent survey of November 2015, showed eight out of 16 people surveyed said they were satisfied with the service. They had not made any suggestions to improve the service. The registered manager's analysis of the survey resulted in an action plan to 'encourage more people to participate in surveys and attend meetings', to make sure everyone was supported to make their views known.

Thirteen out of seventeen staff had responded to the survey and several actions were planned as a result. Plans included, ensure staff know where to access information, to check that staff felt involved in decisions, and to think of new ways for people to be part of their community. Two ideas suggested by staff, to hold a memorial service for people who used to live at the home with yellow balloons and to hold a 1960s themed disco, had taken place. Care staff were proud to be able to tell us they had twice won the provider's monthly award for being the most innovative home in the group for supporting people to engage in their community.

The registered manager told us they were supported in their practice by the provider and attended regular managers' meetings. Care staff told us the registered manager demonstrated the skills of good leadership, because they were not always office based, but worked alongside staff. We saw the registered manager chatting with people who lived at the home, assisting at lunch time and making people hot drinks. A member of care staff told us, "We work as a team. The manager and team leader are good." Another member of care staff told us, "We have team meetings and give and get feedback."

Records of team meetings showed staff were reminded about their responsibilities and discussed ideas to improve people's experience of care. Staff were encouraged to make suggestions and to plan activities they were good at 'to make it more enjoyable'. Records showed that one suggestion, for flower arranging, had a significant impact for one person who had never previously wanted to join in activities, because they had taken part in a flower arranging session.

Care staff told us they liked working at the home, because the registered manager was supportive and they were clear about their roles and responsibilities. Care staff said, "Care assistants support people with bathing, hair and nails. We keep daily notes and body maps if needed, and report any changes to the team leaders" and "The team leader watches everything."

The registered manager understood their responsibilities. They sent us statutory notifications about important events at the home, in accordance with their legal obligations. The registered manager checked care plans were regularly reviewed by senior care staff and that staff kept up-to-date and accurate records of

care. They checked staff managed and administered medicines safely and checked the cook stored food and served meals at safe temperatures. The registered manager shared the results of their checks with staff, so staff knew what actions they needed to take to improve.

Staff were involved in monitoring the quality of the service through a programme of regular checks. For example, a home's diary was used to remind staff to test the fire alarm and to check water temperatures. A member of care staff told us, "We do a monthly mattress audit. We remove the covers to check inside. We do call bell checks. We press all the bells and test all the sockets to make sure they are working and we have an infection prevention audit. Any concerns are raised with the manager."

The provider made regular quality monitoring visits to the home. They looked at the registered manager's quality audit records, to check actions were planned and taken when issues were identified. The provider walked around the building to check any maintenance issues were identified and to assess where refurbishment work was needed. A member of care staff told us, "There is a maintenance book we write in and tell the manager" and "Most things are repaired or replaced promptly." Records showed the most recent maintenance plan, dated September 2015, included issues such as skirting boards, door closers, light fittings and the fire safety officer's recommendations. The fire safety officer had re-inspected since the provider's last quality monitoring visit and was satisfied with the actions taken.

However, improvements were required in the on-going management of risks to the premises. Care staff told us that some issues were resolved immediately, but some issues were not dealt with so promptly. Staff told us they were frustrated they did not know when maintenance issues would be resolved. A member of care staff told us, "Issues are reported and known to the manager, but the maintenance man has to prioritise. The stand aid was replaced straight away, but the light bulb holder in the hallway still needs replacing."

We saw the provider had supplied a new microwave and dishwasher, but the fridge, freezer and a food trolley also needed replacing because the surfaces and seals were worn, which presented risks to effective infection prevention. The cook told us, "They are too old to keep clean properly. The manager knows and has it on the maintenance list."

We observed several areas of the home where the age of equipment and décor did not support staff to maintain a suitable level of infection control and prevention. For example, skirting boards and door frames had paint chipped off and the grout needed replacing around the wash hand basin in the bathroom on the ground floor. In the medicines room the taps at the wash hand basin had lime scale deposits. Bacteria can grow in bare, or unprotected, wood and in lime scale deposits.

Of the issues we observed only the chips to the skirting boards were listed on the provider's latest maintenance plan of September 2015 and these had not been addressed by January 2016. A member of care staff told us, "Refurbishments have been proposed. We were invited to put our suggestions in an envelope in the office" and "The care is good, but the decoration needs to be improved." The member of care staff did not know which suggestions had been accepted or when they were likely to be implemented.

We shared our concerns about the deterioration, due to the age of the building and equipment, with the registered manager. They told us they would conduct a full risk assessment of the premises and share their findings with the provider to agree on priorities and a planned maintenance programme.