Avens Care Homes Limited

# Camplehaye Residential Home

## Inspection report

Lamerton
Tavistock
Devon
PL19 8QD

Tel: 01822612014
Website: www.avenscarehomes.co.uk

Date of inspection visit:
21 August 2018
22 August 2018

Date of publication:
11 October 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| 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

This unannounced comprehensive inspection took place on the 21 and 22 August 2018. The inspection was to follow up to see whether improvements had been made from the previous inspection in August 2017.

Camplehaye Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. It provides accommodation with personal care to a maximum of 44 people. The home provides care for older people, some of whom are living with dementia. The service is a Victorian property over two floors with two modern extensions, and accommodation off four corridor areas. 36 people lived at the home when we visited, six of whom were there short term for respite, and one person was in hospital.

At the last inspection, on 31 August and 4 September 2018, the service was rated requires improvement overall and in safe and well led, and good in effective, caring and responsive. A breach of regulation 12, safe care and treatment was found. This was because risks for people such as fire safety risks, incorrectly set pressure relieving equipment and a lack of detailed of detail in some care plans managing people's challenging behaviours. Improvements in leadership were also needed as service had no registered manager. Several changes of managers over a short period, had been unsettling for people, relatives and staff.

At this inspection we found the service had improved to Good overall with further improvements planned.

The service had a registered manager, they started working at the service in January 2018 and registered in May. 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.

Improvements had been made in fire safety, risks assessments and in using equipment. Staff demonstrated a good awareness of each person's safety and how to minimise risks for them. People's risk assessments were comprehensive with actions taken to reduce the risks as much as possible. Further improvements to reduce risks such as from trailing leads, trip hazards were needed. Most areas were clean and odour free but infection control measures could be improved further.

People, relatives, staff and professionals gave us positive feedback about improvements in leadership and ongoing improvements in the quality of people's care. They spoke positively about improvements in communication, professional development and increased provider support. Quality monitoring systems had improved, with examples of continuous improvements made in response to audits, observation of practice and regular checks of the environment.

People were supported by staff that were caring, compassionate and treated them with the utmost dignity and respect. People concerns and any complaints were listened and responded to and used as opportunities to improve.

People were supported by enough skilled staff so their care and support could be provided at a time and pace convenient for them. Staffing levels were calculated using a dependency tool which was regularly reviewed. Staff understood the signs of abuse and knew how to report concerns, including reporting to external agencies. A detailed recruitment process was in place to ensure people were cared for by suitable staff. People received their prescribed medicines on time and in a safe way.

People were supported by staff who had the skills and knowledge to meet their needs. Recent improvements in training meant staff have better understanding and felt more confident to carry out their roles. People's health was improved by staff who worked with a range of professionals to access healthcare services and promoted improved health through good nutrition and hydration.

Improvements had been made to improve the environment of the home to make it more suitable to meet the needs of people living with dementia. For example, by helping people identify bathroom/toilet areas independently through use clear word/symbol signage. Further improvements were needed to improve wheelchair access at entrance and to outside areas.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

The service was well led by the registered manager and deputy manager, who led by example. People, relatives and staff were regularly consulted and involved in developing the service.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was safe.

People reported feeling safe living at the service, and relatives agreed.

Improvements in fire safety and risk management and to the environment had been made. Further improvements to reduce risks such as from trailing leads and trip hazards were needed.

Most areas were clean and odour free but infection control measures could be improved further.

People were protected because they were arrangements were in place to protect and safeguard people from abuse. Staff knew about their safeguarding responsibilities and how to report suspected abuse, and were confident concerns were responded to.

People's had individual risk assessments which identified actions staff needed to take to reduce them.

People received their medicines on time and in a safe way.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

### Is the service effective?

**Good**

The service was effective.

People were well cared for by staff that had regular training to gain the knowledge and skills to support their care and treatment needs.

Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and acted in accordance with them.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were positive about the choices and quality of food. Staff supported people to improve their health through good nutrition and hydration.

## Is the service caring?

Good

The service was caring.

People received care from staff who developed positive, caring and compassionate relationships with them.

Staff were kind and affectionate towards people and knew what mattered to them.

Staff protected people's privacy and dignity and supported them sensitively with their personal care needs. They promoted people's independence.

People were supported to express their views and were involved in decision making.

## Is the service responsive?

Good

The service was responsive.

People received care which met their individual needs. There were ongoing improvements to make care more person centred.

Care records had improved and had more detailed information for staff about people's physical and mental health needs.

People enjoyed a variety of activities and were supported to socialise. Further improvements in activities were planned to meet needs of people living with dementia.

People knew how to raise concerns and complaints and any concerns were positively responded to.

## Is the service well-led?

Good

The service was well-led.

The culture of the home was open, friendly and welcoming.

People, staff and visiting professionals expressed confidence in the registered manager and deputy manager.

The service had improved quality monitoring systems to monitor the quality of care people received. They made continuous

changes and improvements in response to their findings.

People, relative and staff views were sought and taken into account in how the service was run.

# Camplehaye 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 comprehensive inspection took place on 21 and 22 August 2018 and was unannounced. The inspection team comprised of two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses care service for older people.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home, such as the provider's action plan, and feedback we received from health and social care professionals.

We met with people using the service, and spoke with relatives and a friend. We looked at seven people's care records which included medicine records. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not talk with us.

We spoke with the registered manager, deputy manager, care manager and13 staff which included care staff, housekeeping, maintenance and kitchen staff. We looked at systems for assessing staffing levels, for monitoring staff training and for supervision. We looked at staff rotas and five staff files, which included recruitment records for new staff. We also looked at quality monitoring systems the provider used such as care record, medicine, management and health and safety audits, daily, weekly and monthly checklists, and

at equipment and servicing records. We sought feedback from commissioners, and health and social care professionals who regularly visited the home and received a response from three of them.

Requires Improvement

# Is the service safe?

## Our findings

At our previous inspection in August 2017 we identified a breach of regulation 12, safe care and treatment. This included risks related to fire safety, such as fire escapes not being kept clear. Also, because an expert report which recommended fire safety improvements by replacing fire doors and fitting additional smoke alarms had not been carried out. There were increased risks of skin damage for people because of incorrect pressure relieving mattress equipment and because care plans lacked detail about managing people's challenging behaviours. At this inspection, improvements had been made in all these areas.

Improvements in fire safety had been made. An updated fire safety risk assessment was completed in December 2017 and all recommended actions had been completed. For example, the fire alarm system had been improved and fire doors replaced. Records showed fire safety was properly managed. For example, regular checks of fire exits, extinguishers and emergency lighting were carried out, staff received regular fire safety training and weekly fire drills took place. Each person had a personalised emergency evacuation plan in place which showed the support they would need to evacuate building in an emergency. Learning from a recent fire in another UK care home, the provider purchased new fire evacuation equipment, so people could be safely evacuated from the second floor, if needed.

Accurate information about the recommended setting for each person with a pressure relieving mattress had been obtained from community nursing staff. Daily checks were carried out to ensure recommended settings were maintained.

Where people's behaviours sometimes challenged the service, care plans included more detail for staff about how to manage and reduce those risks. Staff worked with the local mental health team to identify triggers, and used positive behaviour support to minimise distress. Staff demonstrated a good understanding about how to manage challenging behaviours. For example, where a person was sometimes reluctant to have personal care and became verbally aggressive.
One staff member said, "It's the different approaches. Give her time and space. You can de-escalate and diffuse a situation." Staff understood the need to be patient and understanding, to leave person for a while and come back later. Also, the importance of involving the person by encouraging them to wash their own face, so staff could help with other aspects. Regular reviews showed this approach was working well to reassure them.

Personalised risk assessments included a detailed assessment of each person's needs and measures to reduce risks as much as possible. For example, for people with swallowing difficulties to ensure they ate and drank safely. Speech and language therapist advice was sought and followed about dietary modifications needed, such as the use of pureed food and thickeners for fluids to minimise choking risks.

Environmental risk assessments highlighted potential hazards and outlined measures to minimise risks. For example, by regularly checking hot water temperatures were within safe limits. There was an ongoing programme of servicing, repairs, maintenance and redecoration. New flooring had recently been fitted in dining room and lounge areas, which staff said was much easier to keep clean.  Monthly health and safety

checks were undertaken in all areas of the home, with actions taken in response to findings. For example, a check of the call bell system identified a faulty bell, which was being repaired.

However, we identified some environmental risks, which had not been identified through these checks. For example, some loose radiator covers, pedal bins which were not working properly and some trip, slip and fall risks due to trailing leads, and worn carpets. We brought these to the registered managers' attention, who undertook to address these risks. They also updated their health and safety checklist to make it more comprehensive.

Most areas were clean and odour free and staff, but cleanliness could be further improved. One person said, "My room is clean and they fitted a new carpet the day before I arrived." Another said, "They clean my room every day but they haven't done it yet today." We followed up some concerns raised with us prior to the inspection about cleanliness of chairs in the lounge. These were clean and odour free, and had been recently steam cleaned. Communal areas and most bedroom areas of the home were clean and odour free.

However, downstairs on the first day, some tables needed cleaning, a recently used shower looked grubby, some areas were sticky and there was some debris on the floor in some areas. We identified odours in four bedrooms, which had significantly improved when we checked later in the day, with one exception. In the bedroom with an odour, the carpet needed replacement. This had already been identified and new carpet was being fitted later that week. There were normally two cleaning staff on duty, each day, one upstairs and the other downstairs. They followed a daily cleaning routine, which included all bedroom, bathroom and communal areas. The housekeeper explained recent staff sickness meant the regular schedule of deep cleaning had got a bit behind. Cleanliness in all areas of home had improved on the second day.

Staff completed infection control training and regular cleanliness checks were carried out. Where areas for improvement were identified, these were fed back to staff at the time, and were discussed at monthly team meetings. For example, about disposal of waste, use of aprons and cleaning and disinfecting commodes.

In 2017, a food standards agency inspection of the kitchen identified improvements needed in the kitchen. In response, a new fan extraction system was installed and wooden kitchen cupboards were replaced with stainless steel, which improved cleanliness. In July 2018, a further environmental health visit report showed significant improvements had been made but recommended kitchen staff completed additional food hygiene training. A follow up visit was awaited to complete the inspection, and award a rating. We identified an issue about storage of cooked/raw food was identified in one fridge, which the provider addressed immediately.

People felt safe living at the home. Everyone looked comfortable with staff, and the atmosphere was calm and relaxed. People's comments included; "They are very friendly and helpful I have no worries about my safety here," and "Yes I feel very safe here. Everyone is nice and you don't feel lonely. You can talk to any of the staff and they do their best to help and support you."

We found there were sufficient staff on duty to keep people safe and meet their needs. People said there were enough staff to meet their needs, although sometimes staff were busy. People's comments about staffing included, "It depends on time of day," "So far I haven't had to wait long for a staff member to come if I ring my bell," "Staff are very busy here all of the time and you can't always talk to them." Most relatives thought staffing levels were safe, although one relative said, "Sometimes staff are rushed off their feet."

Staff confirmed staffing levels enabled them to keep people safe and meet their care needs. Staff said sometimes they needed more help, particularly at weekends or if a member of staff was off sick. A staff

member speaking about impact of having less staff on duty, said, "It cuts back on our time to sit and chat with residents." Other staff comments included; "We don't always have enough staff especially when people require one to one support. It is improving though as assessments are more robust." Staff meeting minutes showed staff were encouraged to ask for help if they felt they did not have enough staff working on the floor. Management staff regularly worked around the home, which staff and relatives said they appreciated.

The registered manager used two separate dependency assessment tools, to identify each person's staff support needs and planned the staffing rota accordingly. These were reviewed monthly and as people's needs changed. For example, staffing levels increased when a person needed end of life care, and decreased when bed occupancy was lower. The registered manager said staffing levels usually exceeded dependency tool recommendations. Some staff had recently left and new staff were being recruited, although the registered manager said recruiting care staff was difficult in the local area.

Rotas showed they were usually six care staff on in morning, five in the afternoon and three at night. In addition, there were five staff in the housekeeping team, a person in the laundry, kitchen staff and maintenance staff. Rotas showed occasionally staffing levels fell to five care staff in morning, particularly at the weekends. Short term absences such as staff holidays or staff sickness, were covered by existing staff working extra hours. This meant people were usually always cared for by staff they knew, and the service rarely used agency staff.

Effective staff recruitment and selection processes were in place. All pre-employment checks had been carried out including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

People were protected from potential abuse and avoidable harm by staff that had the knowledge and confidence to identify safeguarding concerns. All staff had regular safeguarding training and updating, and were knowledgeable about the different types of abuse. Safeguarding and whistleblowing policies provided information for staff about how to report concerns. One staff had reported poor practice, which was followed up and had been addressed.

The registered manager reported any safeguarding concerns regularly to the local authority and Care Quality Commission, and worked proactively with local professionals to make plans to protect people. For example, where a safeguarding risk had been identified, a risk assessment had been undertaken, a protection plan was in place which all staff were aware of and acted in accordance with to protect people.

The registered manager only admitted people if they had enough staff with the right skills to support them. The service no longer admitted people with more complex behavioural needs related to their dementia. This was confirmed by a significant reduction in safeguarding notifications about incidents between people over the past six months.

People received their medicines safely and on time. People's comments included; "I have taken charge of my medication and the staff check I have taken it on time" and "I know what I should have and I do check it before I take it." Senior care staff known as team leaders administered medicines. They were trained and had yearly assessments to check they did so safely. Staff explained to each person what their medicines were for and checked if people wanted pain relief. Medicines administered were well documented in people's Medicine Administration Records (MAR).

Previously when we visited, there were difficulties with storing medicines at correct temperature because a

storage area upstairs got too hot. At this inspection, all medicines were being stored in a room downstairs. Temperature monitoring showed this issue had been resolved.

There were suitable arrangements for ordering, receiving and disposal of medicines, including those requiring extra security and recording. Detailed policies were in place to guide staff on medicines management, and staff had information on people's individual medicines. Medicines were audited regularly and action taken to follow up any areas for improvement. For example, staff were reminded to sign and date newly opened creams, and to remember to sign the MAR sheets.

Good

# Is the service effective?

## Our findings

People received effective care and treatment to meet their health needs. Staff had the skills, knowledge and understanding they needed to care for people. One person said, "Staff appear very capable." Recent improvements in training had been made, which meant staff had a better understanding of people's health needs and felt more confident to carry out their roles. A staff member said, "Our training is really good." The local GP and community nurse confirmed staff contacted them appropriately about people's health care needs and followed their advice.

The deputy manager was the training lead, and had improved induction arrangements for new staff. Training provision for existing staff had also improved through use of e learning training and workbooks. New care workers were supported to complete the 'Care Certificate' programme, a national training programme for staff new to care. They worked alongside experienced staff to learn about how to provide care to meet people's individual needs. Staff training included first aid, fire safety, moving and handling, food hygiene, safeguarding vulnerable adults, and the Mental Capacity Act.

Regular one to one supervision meetings and observations of staff practice were used to monitor staff skills and attitudes to supporting people living at the service. For example, a review of staff skills using a national care certificate assessment tool identified further staff training needs in moving and handling. So, all staff received update training, which also highlighted additional equipment needs. Additional equipment such as slide sheets and hoist slings were purchased. All moving and handling we observed was in accordance with moving and handling regulations.

Before people came to live at the service a senior member of staff visited them and carried out a detailed pre-admission assessment. The service used evidence based tools to identify people at risk of pressure ulcers (known as bedsores) and those at risk of becoming malnourished. People's individual care plans include clear instructions for care staff about how to meet individual needs. For example, about one person's skin care, including the need for pressure relieving equipment, regular application of cream applying and repositioning. Health professionals praised standards of care and a community nurse said people's skin care was very good.

Two people we met the first day were waiting for the doctor to visit. When we visited one person the next day they said the doctor had prescribed antibiotics and they were feeling much better. People's ongoing health was promoted through regular sight and hearing tests, dentist and chiropody appointments. A lead GP visited weekly and people had regular visits by physiotherapists, occupational therapists, and speech and language therapists.

People and relatives consistently praised the quality of food. Comments included; " The grub is fantastic here," "The food is excellent. Laid out well and plenty of drinks provided," and "It is very nice and there is a fair choice." Staff were aware of people's dietary needs and preferences. At lunchtime, people were asked if they wanted 'seconds' and others who ate less well were asked if they would they like something else. The service used coloured plates and cups, for people living with dementia. This was because staff were aware

research showed they could see them more easily.

Kitchen staff had up to date information about people's nutritional needs and any special diets. Where people were at risk of malnutrition or dehydration, staff monitored how well the person was eating and drinking by keeping daily records of all food and drink taken. Electronic care records also helped staff identify and monitor weight loss and respond appropriately. For example, by offering extra snacks, drinks, or food supplements and seeking advice from a dietician.

Some aspects of the premises were adapted to meet people's needs but others needed further improvement. Improved pictorial and symbol signage throughout the home enabled people to identify bathrooms and communal areas such as the dining room. Corridors were wide, and most but not all, had handrails on both sides, which people could use to hold to steady themselves. A lift was available to the upper floor, and a stairlift to access a second corridor area via steps.

Improvements were needed to help people with wheelchairs and those with mobility needs. One person said, "The front door ramp needs improving as when going out recently I nearly flopped out of my wheelchair." Another person explained, "If I want to go out on the patio I can, but there is a small step and I have difficulties moving my arms so have to be very careful." Although a wheelchair ramp was fitted to the front door, it did not meet disabled access requirements. Instead of one continuous ramp, two separate ramps were fitted, with the edge of a step in between. This made it hazardous for wheelchair users. All doors to the patio had ledges or small steps, which made people's access more difficult. We made the provider and registered manager aware of these difficulties, and they said they would make further improvements.

We recommend the provider seek further advice about wheelchair access to ensure any works carried out meet disabled access requirements.

People's consent to care and treatment was sought in line with requirements of the legislation and guidance. The Mental Capacity Act (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

An audit showed people care records on consent had been updated, with copies of details of all power of attorney arrangements also updated. Where people lacked capacity, mental capacity assessments had been carried out and relatives and professionals consulted about best interest decisions. For example, staff consulted the persons relative where staff identified changes were needed in the room layout of a person who lacked capacity to improve safety and accessibility.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes 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 and found they were.

People's legal rights were protected because staff understood the MCA and what constitutes restrictive practices. The registered manager had made a number of DoLS applications to the local authority DoLS assessment team for people living at the home, and were awaiting assessment. This was where staff recognised those people had some restrictions to their liberty for their safety and in their best interest. For example, the use of key pads on exit doors to prevent some people leaving unaccompanied for their safety.

The local authority had recently approved a DoLS supervisory order for a person living at the home, which we confirmed staff were acting in accordance with.

Good

# Is the service caring?

## Our findings

People were supported by staff who provided kind and compassionate care. People and relatives said staff described a happy welcoming atmosphere. There was a sense of friendship and community amongst people who lived there. People's comments included; "Staff are kind and caring, welcoming" and "Staff are always nice to visitors and relatives as soon as they come in the door. It makes all the difference. We have a summer fete which relatives are invited to attend."

There were lots of private areas people could chat with friends and family. Staff comments included "We provide a safe, homely and friendly atmosphere," and "We treat each person as they want to be treated."

Staff demonstrated sensitivity when a person with memory difficulties, who had had recently lost their husband, asked where he was. The staff member sat next to the person, stroked their arm and gently reminded the person, their husband had recently passed away. They chatted about the person's husband, and involved others nearby in the discussion. This enabled the person to reminisce about their husband in a natural and positive way.

Some people living at the home were unable to comment directly on their care, so we observed staff interactions with people at lunchtime in the dining room. The atmosphere was relaxed and welcoming, people could choose where they wished to sit. The tables were attractive with tablecloths, fresh flower arrangements and condiments, so people could season their own food.

Each person was told individually about the lunch choices available, and staff checked which vegetables people wanted. Visual pictures of the menu each day were displayed on the wall, so to assist people unable to verbally express their meal choices. Where needed, people were offered clothes protectors to keep their clothes clean. People who needed them had plate guards, so they could eat independently.

Meals were attractively presented, with staff on hand to offer any assistance. For example, staff noticed when a person was getting tired and struggled to feed themselves, and offered to assist them. When another person said they were too full for dessert, a member of the staff kindly offered to save some profiteroles for them to enjoy later.

Staff treated people with dignity and respect. People's comments included; Staff are respectful, they knock on your door before coming in, and ask how you want things done" and "They always ensure my door is shut when I am washing and dressing." People's care plans showed what aspects of personal care people could manage independently and which they needed staff support with. For example, one person's care plan said, "[Person] can wash own face but reluctant. Staff to be patient, encourage her to wash what she can." People's care records had details about any religious beliefs and holy communion services were held once a month for people who wished to participate.

People were consulted and involved in decisions about their care. People's comments included; "I am happy with the way I am cared here. I'm able to choose when I get up and when I go to bed." People were

not particularly aware of their care plans, which were kept electronically. However, records showed staff consulted and involved people and relatives in decisions and regular reviews about their care, treatment and wellbeing.

Good

# Is the service responsive?

## Our findings

People received care which met their individual needs. There were ongoing improvements to make care more person centred. People's comments included; "Staff always come around and talk to me," "I like it when they (staff) pop in for a chat," and "Whatever you want, staff try hard to ensure you have got things you like to do."
Several people told us about local people they had met and renewed friendships with since coming to live at the home, and about new friends they had made. One person said, "I can sit with different people and learn about where they used to live." In the afternoon a person organised to get together with a few others for afternoon tea. They said the group got together every day at different times to have a natter, depending on what else was happening.

People said they enjoyed using the garden and large patio area. There were lots of hanging baskets, where people could see these flowers from their room, dining room, conservatory and other areas. In a raised bed there were pumpkins growing ready for Halloween. Care staff spoke confidently about the care they delivered and understood how it contributed to people's health and wellbeing. They knew people well, understood their needs well and cared for them as individuals. Staff spent time chatting to people in their room about things of mutual interest to them. For example, about sport and the local area.

To help support people with Parkinson's disease, (a degenerative neurological condition), a local Parkinson's nurse specialist had carried out a training session with staff about how best to meet their specific needs. For example, staff demonstrated awareness of the importance of giving people their Parkinson's medicine at specific times, to ensure person gained the most benefit from them.

The service had a full-time activity co-ordinator. The staff member had recently left and a new activity co-ordinator had been appointed from within the staff team; they were in their first week in their new role. A weekly pictorial programme of group activities on display showed a varied programme of activities. For example, music, singing, arts and crafts. On the first day, people enjoyed a singing and dancing session in the lounge in the morning and participated in a word quiz game in the afternoon. Where people were confined to their room, or chose not to participate, the co-ordinator spent time doing one to one activities with them such as reading hand massage. There was a day service, three days a week, which several people who lived in the home sometimes joined in, to socialise and undertake planned activities.

The new activity co-ordinator had just completed a six-month dementia course. They were reviewing the activity programme to identify more personalised activities suitable for people living with dementia. For example, arranging more art and craft activities, involving a person who used to be a cookery teacher in setting up a baking group. They were also planning to work with families to develop memory books for each person, by using photographs and mementoes to compile personalised memories about them.

Some people said they would like to go out more often on organised trips. We followed this up with the activity co-ordinator who explained the service didn't have any transport. However, they were pursuing other transport options with local voluntary services. People had expressed an interested in visiting an

aquarium, which they were trying to arrange.

People's care records had improved and care plans and were more detailed about individual needs. For example, detailed moving and handling plans which showed how staff needed to assist a person to mobilise, including details of any equipment needed. Care plan audits showed ongoing efforts were being made to improve completion and accuracy of people's eating and drinking.

People's care records had very variable information about their life before they came to the home, and their hobbies, interests and activities they enjoyed. To improve this, the registered manager gave people coming to live at the home, a 'This is me' form devised by Alzheimer's society. This helped new people and families provide more details about the person.

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Each person's care plans included a communication section about their individual communication needs. For example, about any visual problems or hearing loss and details for staff about how to help people communicate effectively. For example, that a person sometimes used words in the wrong context. A care plan for another person said, "[Person] struggles to make views and wishes known. Provide simple clear choices, allowing time to respond. Use clear uncomplicated language. Check for understanding and repeat."

Although no one was receiving end of life care when we visited, health professionals praised end of life care at the home. They said people were supported to have a comfortable, dignified and pain-free death. Where people had expressed any advanced decisions about resuscitation, the withdrawal of treatment or preferred funeral arrangements, these were recorded in their care plan. This gave people the opportunity to let other family members, friends and professionals know what was important for them in the future, should they no longer be able to express their views.

People's concerns and complaints were listened and responded to. People said staff listened to them and resolved any day to day concerns. People's comments included; "You can talk to them at any time" and "If I have anything to complain about I would do so to the highest person I could to ensure it is dealt with to my satisfaction."

The provider had a complaints policy and procedure. Written information about how to raise a complaint was in each person's room and was on display in the home. The complaints log showed one complaint was raised by a relative about difficulties speaking to their family member by phone. In response, new signal boosters were installed around the home to strengthen the signal, and more cordless phones purchased. This showed complaints were taken seriously and used to identify further improvements.

Good

# Is the service well-led?

## Our findings

The service was well led. The service had a registered manager. 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.

A new registered manager was appointed in January 2018, and a new deputy manager had also been appointed. People, relatives and professionals expressed confidence in the management team, although a couple of people were not sure who registered manager was. A relative said, "I have confidence in the new manager, she is friendly and approachable, I've seen her helping on the floor, and coming in at weekends."

Communication with external professionals had improved because the registered manager has contacted local social services teams, community nurses, therapist and mental health teams. They worked in partnership with them to gain a clear understanding of roles and expectations. This strengthened relationships and ensured local teams worked well together to meet people's individual needs. The registered manager was in day-to-day charge, supported by a deputy manager and a care manager. The deputy manager spent a day each week working alongside staff to observe staff practice and offered support and further training where needed. The care manager worked two to three shifts a week to monitor and support staff team, and led on care plans. A team leader was in charge on each shift, including at night. Out of hours, they took turns to provide "on call" and were available to staff for advice, support and came in to help, if needed.

The registered manager described their leadership style as "firm but fair." They praised the additional support they received from both providers, who were more involved in the home than previously. For example, one director was there most days. The second director visited two to three times a week, met regularly with the registered manager and undertook quality monitoring.

Staff spoke positively about teamwork and said they felt well supported. Staff comments included; "Everyone is working really hard, and doing their best," and (The managers) are approachable, responsive and morale is improving." Several team leaders we spoke with described how they were being developed to take on additional supervisory and lead role responsibilities.

Daily staff handover meetings were held; electronic record handover, communication books and whiteboards were used to pass information between staff. For example, about people's appointments and prescription changes.
Improvements in quality monitoring had been made since the previous inspection. The provider information showed the new management team sought support from the local authority Quality Assurance and Improvement Team to improve their quality monitoring systems. The service had a service improvement plan, which detailed improvements completed and those planned.

The service used a range of quality monitoring systems such as audits of care records, health and safety and

medicines management. Audit action plans showed the service made continuous improvements in response to their findings. For example, through feedback to staff individually and at team meetings about areas they could improve on further such as in relation to, hygiene and infection control, as well as arranging specific training where needed, such as fire warden training.

All accidents and incidents reported were monitored to look for trends and identify further changes needed to prevent recurrent risks. For example, falls analysis in February 2018 showed people had more falls in the evening. So, some 12-hour shifts from 9am to 9pm were introduced to increase staff support in the evenings. The July 2018 report showed these measures were effective as falls had reduced. Where mistakes occurred, staff were open and honest with people. For example, in relation to medicine errors.

People were consulted and involved in day to day decisions about the running of the home through monthly meetings. For example, some people said they found the menu a bit repetitive. So, people were asked what they would like to see on the menu. As a result, unpopular choices were removed and the menu updated to incorporate people's preferences. People were also consulted about the recent redecoration of the lounge, including deciding on the décor and room lay out. When we visited, surveys seeking further feedback from people, relatives and staff were being circulated, so further areas for improvement could be identified.

Staff were consulted and involved in decision making at the home and regular staff meetings were held. Minutes showed people's individual care needs were discussed, as was role of the key worker. The provider information return showed a weekly 'surgery' was held to enable staff to raise areas of concern, queries. A suggestion box also encouraged staff ideas for improvement.

The provider information return showed the service used the Skills for Care code of conduct and the '6C's' to promote a caring and supportive ethos. The 6 C's include care, compassion, communication, competence, courage and commitment. Staff completed equality and diversity training. staff were promoting ongoing improvements in inclusion, dignity and respect for people through observation and supervision. They identified and tackled instances where a member of staff spoke about people in ways which depersonalised them. These were discussed at team meetings for learning. For example, when a staff member referred to a person by their room number, or used terms such "feeders" to describe people who needed staff support with eating.

The service had recently introduced lead roles to promote evidence based practice. Individual staff had lead roles for training and development, infection control, continence care, care plans and medicines management. This showed the service was committed to ongoing improvements.

The registered manager had notified the Care Quality Commission (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 their previous inspection report in the home, and on their website in accordance with the regulations.