Care Quality Commission

Roseberry Care Centres GB Limited

Moorend Place

Inspection report

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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?	Requires Improvement

Overall summary

This inspection took place on 16 April 2015. This was an unannounced inspection which meant the staff and registered provider did not know we would be visiting. The service was last inspected on 29 July 2014. At the last inspection we found the service was not meeting the requirements of the following three regulations: the care and welfare of people who use services, supporting workers and assessing and monitoring the quality of service provision. As a response to the last inspection the provider sent a report to the Care Quality Commission of the action they would take to become compliant with the regulations. The provider informed us they would be fully compliant by the end of November 2014. At this inspection we found that the required improvements had been made.

Moorend Place is a nursing service that provides care for up to 58 older people. It is a purpose built care service. At the time of our inspection 51 people were living at the service.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are "registered persons". Registered persons have a and has the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we observed domestic staff cleaning different parts of the service. However, we found there were malodours on one of the stairways and in the lounge areas of the home. We spoke with the registered manager who assured us that they would take action to address these concerns.

We saw that the system in place to ensure each person had access to a call bell on a lead unless it presented a risk to them needed to be more robust. A lead enables the call bell to be positioned so the person can call for staff assistance. We spoke with the registered manager; they assured us that a call bell lead would be available for people to use in their room unless it presented a risk and regular checks would be completed to ensure they were plugged in and left in reach for people to use.

People told us they felt safe and were treated with dignity and respect. Our discussions with staff told us they were fully aware of how to raise any safeguarding issues and were confident the senior staff in the service would listen.

The service had appropriate arrangements in place to manage medicines so that people were protected from the risks associated with medicines.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people.

Some people had personalised their rooms and they reflected their personalities and interests. We saw that the environment within the home could be improved to make it more dementia friendly. For example, some areas of decoration of the service could be improved, the signage and signs could be clearer and the clocks needed to be set at the right time.

People spoken with told us they were satisfied with the quality of care they had received and made positive comments about the staff. Relatives spoken with also made positive comments about the care their family members had received and about the staff working at the service.

People had a written care plan in place. People's records were updated on a daily basis.

Individual risk assessments were completed for people so that identifiable risks were managed effectively. However, we found one person did not have a repositioning chart and another person did not have an observation chart in place. It is important that an accurate record of the care provided is recorded by staff. The person who required repositioning told us they received the support they needed from the night staff. We spoke with the registered manager; they assured us that these charts would be put in place.

People and/or their representatives were included in the completion of their care plans and they were reviewed regularly and in response to changes. There was evidence of involvement from other professionals such as doctors, optician, tissue viability nurses and speech and language practitioners.

People's nutritional needs were monitored and actions taken where required. Most people made positive comments about the food. People's dietary needs were being met.

Staff told us they enjoyed caring for people living at the service. Staff were able to describe people's individual needs, likes and dislikes and the name people preferred to be called by. Staff completed induction, training and received ongoing support. Staff received specialised training to meet the needs of people they supported.

We saw the service promoted people's wellbeing by taking account of their needs including daytime activities. There was a range of activities available which included: sing alongs, arts and crafts and games. However, we saw that some people living with dementia may benefit if they were provided with sensory and/or soft objects or items to stimulate memory for example, items to hold their attention and divert incidents of behaviour that challenged others.

The provider had a complaint's process in place. We found the service had responded to people and/or their representative's concerns, investigated them and had taken action to address their concerns.

There were regular meetings with people living at the service; this showed the service actively sought people's view so they could share their experience of care.

Summary of findings

There were regular relatives meeting held at the service. A copy of the latest relatives meeting minutes was available for people and visitors to the service to read in the reception area. There was a relative's board where people's relatives or representatives were kept informed about information relevant to them.

Accidents and untoward occurrences were monitored by the registered manager. We found that this monitoring could be improved by analysing occurrences in more detail to ensure any trends were identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some areas of the service were not safe. Accidents and untoward occurrences were monitored by the registered manager. We found that this monitoring could be improved by analysing occurrences in more detail to ensure any trends were identified. This told us there could be a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety not managed.

We found that there were malodours in the communal lounges within the service which told us that the furnishings within the rooms were not being sufficiently cleaned.

People told us they felt "safe". Staff were fully aware of how to raise any safeguarding issues. People had individual risk assessments in place so that staff could identify and manage any risks appropriately.

Is the service effective?

Good

The service was effective. Staff received induction and refresher training to maintain and update their skills. Staff were supported to deliver care and treatment safely and to an appropriate standard.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Most people made positive comments about the quality of food provided and told us their preferences and dietary needs were accommodated.

Is the service caring?

Good

The service was caring. People and relatives made positive comments about the staff and told us they were treated with dignity and respect. The staff were described as being friendly and approachable.

During the inspection we observed staff giving care and assistance to people. They were respectful and treated people in a caring and supportive way.

Staff enjoyed working at the service. They knew people well and were able to describe people's individual likes and dislikes, the name they preferred to be called by and their personal care needs.

Is the service responsive?

Good

The service was responsive. People's care planning was centred round the person. Care plans were reviewed regularly and in response to any change in people's needs.

Staff handovers enabled information about people's wellbeing and care needs to be shared effectively and responsively.

Summary of findings

The service promoted people's wellbeing by providing daytime activities. However, we found that some of the people living with dementia may benefit from having more access to sensory and/or soft items and items to stimulate memory.

Is the service well-led?

Requires Improvement

Some areas of the service were not well led. There were regular checks completed by the registered manager and senior staff within the service to assess and improve the quality of the service provided. However, we found that some of the checks needed to be more robust to ensure the improvements that had been made at the service were sustained.

Most people spoken with knew who the registered manager was and knew they could speak with her if they had any concerns. The registered manager actively sought people and their representative's views by holding regular meetings at the service.

Staff made positive comments about the staff team working at the service. Staff meetings took place to review the quality of service provided and to identify where improvements could be made.

Moorend Place

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 16 April 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection was led by an adult social care inspector who was accompanied by a second adult social care inspector and a specialist advisor and an expert by experience. The specialist advisor was a registered nurse who had experience in caring for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was last inspected on 29 July 2014 and was found to be in breach of three regulations.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also spoke with a GP who regularly visited the service.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seventeen people living at the service, ten relatives, the registered manager, the deputy manager, two nurses, a team leader, two care workers, the activities worker, the administrator and the cook. We looked round different areas of the service; the communal areas, bathrooms, toilets, storage rooms and with their permission where able, some people's rooms. We reviewed a range of records including the following: five people's care records, ten people's personal hygiene and daily records, four people's medication administration records, three staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Most of the people spoken with told us they felt "safe" and had no worries or concerns. Their comments included: "I find it very nice, I like it here, feel safe" and "I've wouldn't be afraid to say anything if I wanted to". However, one person told us they did not feel safe at night because other people could open their door and come in their room. They also told us that staff did not always ensure their call bell was placed in reach so they could call for assistance. The person said: "sometimes the call bell (lead) is behind the bed, I can't reach it". People told us that when they used their call bell staff responded to their calls for assistance during the day or night. People's comments included: "they can't always do it immediately if they're [staff] busy" and "I don't wait long".

During the inspection we saw there was not a robust system in place to ensure a call bell lead was available for people to use in their bedrooms. A lead enables a call bell to be positioned near the person so they can easily call for staff assistance. For example, in two people's rooms there was no call bell lead plugged in for people to use to call for assistance. Another person's call bell lead was unplugged. Staff spoken with told us the person sometimes pulled it out. We spoke with the registered manager; they assured us that they would speak with the service's maintenance worker to ensure there was a call bell lead available for people to use in their rooms unless it presented a risk to the person. They also told us they would speak with staff about the importance of ensuring that a call bell was plugged in and left in reach for people to use to call for assistance from staff during the day and night. They assured us that regular checks would be made.

All the relatives spoken with felt their family member was in a safe place. However, one relative expressed concerns about other people living at the service coming into their family member's room. Although staff had managed the situation they were concerned that this may reoccur.

We saw evidence that the registered manager reviewed the staffing levels within the service on a regular basis by using a dependency assessment tool. This is a tool used to calculate the number of staff they needed with the right mix of skills to ensure people received appropriate care. For example, the number of nurses and number of care assistants required for each unit. However, our observations during the inspection and the feedback received from staff told us that people who had behaviour that could challenge others fluctuated on a daily basis.

We saw examples during the inspection where people's behaviour negatively impacted on people's experience of living at the service. For example, we observed a staff member supporting a person to eat in one of the lounge areas. We saw on two occasions where they had to stop supporting the person to support another person who had entered the lounge. Another person who was trying to eat their lunch in one of the lounges was interrupted by another person living at the service on two occasions. On the first occasion the person pushed the table they were eating their meal from, so their soup spilt over the rest of their meal and their napkin. No staff member was present to intervene. The person did not call out for assistance and lost interest in eating. People benefit from having a calm and conducive atmosphere to eat their meals. We shared this information with the registered manager regarding the importance of staffing levels reflecting the fluctuating level of need of people, to ensure people's needs were met and people needs were not impacted on negatively due other people's behaviour.

The service had a process in place for staff to record accidents and untoward occurrences. The registered manager told us the occurrences were monitored to identify any trends and prevent recurrences where possible. However, we found that the analysis of untoward occurrences needed to be more detailed to ensure trends or patterns were identified. For example, the environmental or social factors, psychological and emotional factors, physical and cognitive factors present. This told us there could be a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety not managed. We spoke with the registered manager who assured us that they would review the service's monitoring process.

We reviewed people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to put measures in place to reduce the risks to the person. However, we found one person who needed to be regularly repositioned to reduce their risk of developing a pressure sore did not have a chart in place to record the repositioning. We spoke with the person, who

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told us that staff made sure they used a pressure cushion during the day and that they received regular support during the night. It is important that an accurate record is maintained about the care people receive. We spoke with the nurse in charge; they assured us that a chart would be put in place.

In another person's care records we saw the person needed regular observation checks to be completed. Staff spoken with told us they carried out regular checks, but there was not a chart in place to record the observations. We spoke with the registered manager and the clinical lead for the service regarding these omissions. They assured us that regular checks would be completed to ensure charts were in place for people who required repositioning or observation checks to be completed.

We reviewed three staff recruitment records. The records contained a range of information including the following: application, interview records, Disclosure and Barring Service (DBS) check, references including one from the applicant's most recent employer and employment contract. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We also saw evidence where applicable, that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. However, we saw that one staff member had not completed the dates of their employment history in their application form. It is important that applicants provide full details of their previous employers to ensure that people are cared for by suitably qualified staff. We spoke with the registered manager; they assured us that they would obtain the information and ensure checks were completed so this did not reoccur in the future.

We gathered information from the local authority and reviewed the notifications sent to the Care Quality Commission. The registered manager had a process in place to respond to and record safeguarding vulnerable adults concerns. We saw a copy of the local authority safeguarding adult's protocols and the registered manager told us relevant staff followed them to safeguard people from harm. We reviewed the service's safeguarding records and saw evidence that these protocols had been followed.

Staff received training in safeguarding vulnerable adults. It was clear from discussions with staff that they were fully aware of how to raise any safeguarding issues and they were confident the senior staff in the service would listen.

We spoke with the administrator at the service; they gave us details of the provider's care service software management system to manage people's personal allowances. The administrator told us the provider paid for any expenditure. For example, for the hairdresser or the chiropodist. A receipt was issued to people and/or their representative when they gave the service any monies. The receipt was also signed by the administrator or a senior staff member if the person was not able to sign to verify the transaction. A statement could be generated for each person with a personal allowance. The administrator also told us that the provider's administration manager visited the service to complete checks. We found there were satisfactory arrangements in place to record people's financial transactions to safeguard people using the service from financial abuse.

We looked at the systems in place for managing medicines in the service. The service had policies, procedures and systems for managing medicines and copies of these were available for staff to follow. Medicines were only handled and administered by trained senior care workers and nurses. Having well trained staff reduced the risk of making mistakes with medicines.

We checked a sample of people's Medication Administration Records (MAR). We did not identify any concerns in the sample of MARs checked. Some medicines, such as painkillers, were prescribed to be taken only 'when required'. Some people living in the service could ask for these medicines when they needed them, although some people with poor communication skills were unable to do so. We saw that information had been prepared for staff to follow to enable them to support people to take their medicines safely and that this information was detailed and personalised. For example, how a person communicated they were in pain if they were unable to tell staff verbally. During the inspection we observed a nurse asking people if they were in pain and whether they needed any medication. The nurse was kind and patient.

An external medication audit had been completed by a pharmacist in February 2014. It included actions which the registered manager had completed. The senior staff at the service completed regular medication audits and identified any action staff needed to take. We looked at the medication audits completed in March 2015 and April 2015. We saw evidence that action had been taken when errors had been identified and/or to improve the management of

Requires Improvement

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medicines. This told us that people were protected from the risks associated with medicines because the service had appropriate arrangements in place to manage medicines.

All the people and relatives spoken with did not raise any concerns about the cleanliness of the home. One person commented: “everything is really good, cleanliness – all beautifully clean”. The service had a nominated infection control lead and regular infection control audits were completed at the service. We reviewed the audit that had been completed on the 15 April 2015 which included an action plan for the service to complete to make further improvements. For example, the audit had identified that some areas of flooring needed attention.

During our inspection we observed that staff wore gloves and aprons where required and we saw these were readily accessible throughout the service. Hand gel was available in communal areas. We saw that the communal bathrooms and toilets were clean and tidy. A cleaning schedule was in place for domestic staff to follow. However, we found that there were malodours on one of the stairways and in the lounge areas on both units. We also saw that some of the pressure cushions used on chairs required cleaning. We spoke with the registered manager; they told us that the night staff undertook the cleaning of these areas. They assured us that they would speak with night staff to ensure these areas of concern were addressed and regular checks would be undertaken.

There was a system in place for staff to record any areas in the service that needed attention and a maintenance worker was employed by the service. We saw evidence that regular checks were undertaken of the premises and equipment. For example, call bell system, window restricters, and fire system checks. There was also a maintenance comments book in the reception area for visitors to record any concerns. A visitor had noted a comment in February 2015 and we saw that action had been taken in response to their concern.

Good

Is the service effective?

Our findings

People spoken with told us they were satisfied with the quality of care they had received. During the inspection we observed staff explaining their actions to people and gaining consent.

Relatives spoken with told us they were very satisfied with the quality of care their family member was provided with and were fully involved. Their comments included: "I personally like the home, I have really warmed to [the registered manager]", "the practice I've seen has been good", "really like the activities worker [name], she is really trying to do nice things for people" "there are drinks always available, the food is very good. If someone asks for things staff will always get it", "this is the best home she's [family member] ever been in. Care is good, staff are excellent. People who run the place do the job they're supposed to do" and "they [staff] come in to her every hour and (at night) they turn her every two hours, it's all logged" and "the care is good, they saved her [family member's] life when she first came in here".

We noticed that some of the lounge areas did not have a sufficient number of small tables so people could place their drinks on them. We spoke with the registered manager, they told us that additional tables had been ordered who told us that the service had recently ordered tables and they were due to be collected shortly. We also noticed that the environment in the home could be improved so it was more dementia friendly. For example, some areas of decoration of the service could be improved, the signage and signs could be clearer and the clocks needed to be set at the right time. We shared this information with the registered manager and deputy manager.

In people's records we found evidence of involvement from other professionals such as doctors, optician, falls assessment team, tissue viability nurses and speech and language practitioners. During the inspection we spoke with a GP who regularly visited the home. They made positive comments about the staff and how well they supported people living with dementia. The service had a written and verbal process in place for the staff handover between shifts. This helped staff to identify and respond effectively to people's changing needs.

People could choose to eat their meals in the dining room, lounge areas or in their room. Most people told us they were satisfied with the quality of the food. Their comments included: "food is really nice, plenty of choice", "I enjoy all the food", "the food's decent and well cooked, they [staff] offer alternatives to eat", "always plenty to eat, she's a good cook" and "foods very good". Two people thought the food could be improved. Their comments included; "food's passable" and "I don't like the food". One person told us they received a soft diet and that staff always made sure they received the yoghurt they liked.

We spoke with the cook. They described how they planned people's meals and they described people's individual likes and dislikes. They also told us about the comments book they used to obtain feedback from people living at the service. They said "I ask residents for feedback about the meal, if I'm doing something wrong I want to know". They also described how care assistants asked people for their meal preferences every day after breakfast. They were aware of the people who needed a specialised diet and/or soft diet. They showed us a folder which included details of people's diets, fluid needs and preferences. This told us that people's preferences and dietary needs were being met. We saw that the service also used a pictorial menu which they could take to people to show the different options available. However, there were no details of the day's menu available in the dining rooms. People living with dementia may forget what is on the menu so having an up to date menu board in place may aid their memory in the choices available. We also noticed that people were not always provided with napkins so some people ended up wiping their hands on their clothes or the table cloths.

The registered manager used a staff training spreadsheet to monitor the training completed by staff. We looked at staff records and saw staff received training relevant to their role. The training provided covered a range of areas including the following: moving and handling, fire safety, infection control, dignity and respect, challenging behaviour, health and safety, Mental Capacity Act 2005 (MCA), and Deprivation of Liberty Safeguards (DoLS). The nurses completed specialised training to meet the needs of people they supported.

In the service's comments book a visitor had recorded a positive comment about staff's response to a fire alarm.

Good

Is the service effective?

They commented; “fire alarms activated this evening, staff on duty showed excellent organisation and efficient response”. This showed that the fire drill training completed by staff had been effective.

At our previous inspection in July 2014 and we had some concerns about the way staff had been supported within the service. We asked the provider to take action to address these concerns and to send us a plan of how they intended to do this. At this inspection we found that the required improvements had been made. The registered manager had a supervision and annual appraisal schedule in place for staff. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We saw evidence on staff files that they had received regular supervisions and an appraisal where appropriate. Staff spoken with told us they felt supported by the registered manager and encouraged to maintain and develop their skills. One staff member commented: “we have a got a good team, [registered manager] is supportive and always makes time for you”, This told us that staff were supported to develop their skills and deliver safe care to an appropriate standard.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The provider had policies and procedures in relation to the MCA and DoLS. The service was aware of the need to and had submitted applications to the DoLS supervisory body who are the responsible body to consider and authorise where they deem it necessary that any restrictions in place are in the best interests of the person. During the inspection we did not observe any evidence of unlawful restriction. For example, people being restricted from leaving the premises.

Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently.

Good

Is the service caring?

Our findings

Most people spoken with made positive comments about the staff and told us they were treated with dignity and respect. Their comments included: "I love it here, they [staff] are ever so pleasant", " I find it very nice", "It's okay here, they're [staff] very obliging", "it's nice enough" and "I'm comfortable and happy here, everybody's [staff] very friendly, I've no faults with it at all" "staff are lovely" and "decent folk [staff] who'll always listen, not bad staff at all, they're handpicked". Two people told us that most staff of the staff were nice but some were not as nice as others.

During the inspection we were greeted by the service's pet cat. One person told us that us the cats name was "Boris". We saw that people enjoyed interacting with the cat.

Relatives told us their family members were treated with respect and made positive comments about the staff. Their comments included: "for me, the interaction, kindness, effort and atmosphere means much more than the paperwork", "all the staff are really approachable", "it's cheerful and friendly, welcoming - I'm here every day" and "I'm really happy with her [family member] being here - it seems like a really happy place. People are happy and well looked after".

We saw people could choose where to spend their time. One person commented: "I pretty much do what I want; I can get up and go to bed when I want". Some people had chosen to stay in their rooms or to sit in one of the lounges. Other people liked to walk up and down the corridors. One person told us that they would like to access the garden area without asking staff to open the door in one of the lounge areas. They commented: "we can't open that door to go out; we have to get someone [staff] to open it. It would be nice to go out ourselves". We spoke with staff, they told us that the door was kept locked because there was a step and some people may need assistance. We shared this information with the registered manager; they told us they would speak with the provider regarding improving the access to the garden.

The registered manager told us there was a dignity champion at the service. The key aim of a dignity champion is to influence and inform colleagues and to stand up and challenge any disrespectful behaviour rather than just tolerate it. It was clear from our discussions with staff that they enjoyed caring for people living at the service. One staff member commented "I absolutely love it, I love my job". Staff spoken with were able to describe people's individual needs, likes and dislikes and the name people preferred to be called by.

We observed one staff member asking a person if they liked the music playing on their radio. The person used facial gestures to communicate their preference. However, we noticed during the inspection that staff did not always check whether people wanted the television on in the lounge or if they were happy with the choice of programme. One person commented: "I don't like this [programme], the staff put it on, and we never get to choose". We shared this information with the registered manager; they told us they would speak with staff.

We observed staff giving care and assistance to people throughout the inspection. They were respectful and treated people in a caring and supportive way. We also observed that staff adapted their communication style to meet the needs of the person they were supporting. For example, kneeling down and speaking with the person on their level in a chair. Staff members spoken with described how they maintained people's privacy and dignity. For example, knocking on people's doors and discreetly asking people if they needed to go to the toilet. During the inspection we noticed that the level of discretion varied amongst the staff. For example, we observed two staff members asking a person if they wanted to go to the toilet, one quietly asked and the other one could easily be heard by other people in the room.

Where people found it difficult to communicate when they were in pain, the nurses and senior care workers used a pain tool to help people tell them where the pain was located and the level. We also saw there was information kept with people's MAR charts which gave details on how people communicated they were in pain. For example, this could be by facial expression or by demonstrating a particular behaviour.

In the reception area of the service there was a range of information available for people and/or their representatives. Details of the advocacy services had been included in the service user guide. There was a communication board for relatives and/or representatives which included a laminated copy of the latest relatives meeting.

Good

Is the service caring?

The registered manager told us that care staff attended end of life training as part of their induction training but they were looking at obtaining more in depth training for staff. They told us that advice was also available from the local hospice to utilise and to ensure people had a comfortable and dignified death

Good

Is the service responsive?

Our findings

At the last inspection we found the service was not meeting the requirements of the regulation for care and welfare of people who used the service. We asked the provider to take action to address these concerns and to send us a plan of how they intended to do this. At this inspection we found that the required improvements had been made.

People's care records showed that people had a written plan in place with details of their planned care. We found people's care planning was individualised. An account of the person, their personality and life experience, their religious and spiritual beliefs had been recorded in their records. We saw the level of detail of people's life experience and personality varied in people's records. This could lead to an increased focus on the person's condition rather than the person. People's individual needs had been assessed and any risks identified. We found evidence that relatives and representatives had been involved in the planning of people's care.

We found people's care plans and risk assessments were reviewed regularly and in response to any change in needs. However, we found that there were omissions in some of the detail of care plans. For example, there was a staff signature missing on one person's assessment and the details of their dementia condition Lewy Body was minimal. Detailed care plans help staff provide appropriate care that meets people's needs. One person's Malnutrition Universal Screening Tool [MUST] had not been fully completed. We spoke with the deputy manager, they told us that the person was due to be seen by the GP as staff had identified they required a review due to weight loss. The deputy manager told us they would speak to staff regarding the omission and completed the MUST tool during the inspection.

There was a written and verbal system in place for staff handover between shifts so that information was shared about people's wellbeing and care needs.

The service promoted people's wellbeing by providing daytime activities. We saw that there was a range of activities available for people to participate in, which included: games, baking, arts and crafts and quizzes. There was an activities boards displayed in different areas of the service. On the morning of the inspection a group of people attended a coffee morning in the service's dementia cafe on the ground floor. In the afternoon we saw people joining in a singing and dancing activity in one of the lounge areas. We spoke with the activities worker, who told us that they had a timetable of activities but they adopted a flexible approach as it all depended on what people wanted to do. They also evaluated each activity on each unit with people to see if they enjoyed it and this was shared with the registered manager.

Although we saw that a range of activities were being provided by the service, we saw that people had not been encouraged by care staff to access sensory items, soft items or memory items which can be of some benefit to people living with dementia. For example, we observed a person picking up a necklace they had found hanging on a door handle. We had observed this person interrupting a person trying to eat, but on picking up the necklace, they sat in a chair and focussed their attention on the item. We shared our observations with the registered manager and clinical manager.

The complaints process was on display at the service. However, we saw that this needed updating as the contact details of the regional manager had changed. We reviewed the service's complaints log. We found the service had responded to people and/or their representative's concerns, investigated them and taken action to address their concerns. People spoken with told us they did not have any concerns or complaints and if they did they would speak with staff or a family member. Relatives spoken with told us they would speak with the nurse in charge or the registered manager if they had a concern or complaint.

Requires Improvement

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Our findings

At the last inspection we found the service was not meeting the requirements of the regulation for assessing and monitoring of the service. We asked the provider to take action to address these concerns and to send us a plan of how they intended to do this. At this inspection we found that the required improvements had been made.

There were planned and regular checks completed by senior managers within the service to check the quality of the service provided. The checks completed at the service included: medication audits, incident and untoward occurrences, care plan checks, equipment checks and infection control audits. However, our observations and findings during the inspection showed that further improvements were required to ensure the improvements made to the service were sustained. Our findings showed the system to check people's care records and/or daily records needed to be more robust to ensure people received their required care. For example, one person did not have a repositioning chart in place. We spoke with the registered manager, who assured us that robust and regular checks would be undertaken.

Most people knew who the registered manager was and knew they could ask to speak with them if they had any concerns. Staff spoken with told us they would speak with the registered manager or deputy manager if they had any concerns.

The service held discussions with a sample of people living at the service in January 2015. This discussion centred around what people like to eat and promoting choice. Another discussion in January 2015 was about the activities people like to do. One person said they liked to dust around and make it clean. During the inspection we saw the person dusting in one of the units. We looked at the service's newsletter for February 2015. It provided details of the new staff who had recently started working at the service and staff waiting to start. It also included details of a coffee morning for people living at the service and their relatives.

The registered manager informed us that the provider had recently sent out a quality assurance survey to relatives. The service held regular relatives meeting. We looked at the minutes of the relatives meetings held in October 2014 and February 2015. We saw that a range of topics had been discussed at the meetings which included: planning of meetings, activities, maintenance comments book and missing laundry. The new activities worker and new clinical lead were introduced to relatives at the February meeting. We saw a copy of the latest relatives meeting minutes was displayed on the relative's notice board in the reception area. There was also a maintenance comments book in which visitors could write any concerns about the maintenance of the service. The service also had a comments book available for visitors to write in. This showed the service actively sought the views of people's relatives and representatives.

There was a staff organisation chart with pictures displayed in the reception area. During the inspection we found it easy to identify staff as they were wearing name badges. Staff wearing a name badge can assist people who have a memory impairment who cannot always remember staff names. It also allows visitors to the service to identify the staff member they have seen or spoken with.

We saw that a range of staff meetings were held at the service including: team leader and managers meeting, kitchen staff meetings and domestic staff meetings. The service also held heads of department flash meetings which included urgent matters that required discussion and/or immediate action. Regular staff meetings help to ensure people receive a good quality service at all times. A staff survey had been completed at the beginning of 2015 and the results had been displayed in the reception area.

There were planned and regular checks completed by senior managers within the service to check the quality of the service provided. The checks completed at the service included: medication audits, incident and untoward occurrences monitoring, care plan checks, equipment checks and infection control audits. These checks were used to identify action to continuously improve the service. However, the malodours we found during the inspection showed the infection audit needed to be more robust. We also found that the system to ensure people's care records and/or daily records did not contain omissions needed to be more robust. We spoke with the registered manager, who assured us that robust and regular checks would be undertaken.

The provider's regional manager regularly visited the service to complete checks. We reviewed the audit completed in January 2015. The audit covered a range of areas including the following: key performance indicators

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regarding weight loss and pressure sores, hospital admissions, medication audits, infection control, environment, complaints and concerns, incidents, activities, staff training and supervision, staff meetings and relatives and resident meetings completed. The audit included details of the action completed as a result of the last audit and a new action plan for the manager to complete to make further improvements.

During the inspection the registered manager provided us with a number of policies and procedures. We noted that two of the policies provided had not been reviewed since 2013. For example, the medication policy and the public interest disclosure (whistleblowing) policy. It is important that policies are regularly reviewed to ensure they reflect current legislation.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.