Saffron Care Ltd

Glenkealey

Inspection report

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Date of inspection visit:
19 October 2016

Date of publication:
18 November 2016

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 inspection took place on the 19 October 2016 and was unannounced. The inspection started at 06.50am, to allow us to meet with the night staff and see how staff duties were organised for the day.

Glenkealey provides care and accommodation for up to 15 people, and was full at the time of the inspection. People living at the home were older people, some but not all of whom were living with dementia or had mental health needs.

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

Glenkealey had previously been inspected on 4 and 8 June 2015, when they had been rated as Requires Improvement overall. There had been breaches of Regulations 9 (Person centred care), 12 (Safe care and treatment) and 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at that time. The provider sent us an action plan telling us what actions they intended to take to put things right.

On this inspection we found actions had been taken to address the concerns identified on that inspection. For example we found that care plans had been re-written to include more information about the person's wishes with regards to their care. There had been a significant increase in the activities provided to help entertain and engage people in accordance with their wishes and choices. These had improved the homes ratings in key areas from 'Requires improvement' to 'Good'. We identified some concerns in relation to people's safety, which meant the home was still in breach of Regulation 12 (Safe Care and Treatment). However, the registered manager took immediate action to address the majority of the issues while we were still at the home, and following the inspection confirmed to us the further actions they had taken to prevent a re-occurrence.

On this inspection we found people had not always received safe care or were not being protected by the home's systems for assessing and mitigating risk. Sufficient information to help staff assess the risks to one person from poor hydration was not being recorded. Eye drops which needed refrigeration, were not being

stored at the correct temperature to ensure they were safe and effective. Risks to people from the environment had not always been assessed; not all areas had been well maintained, and robust infection control practices were not always put into practice. We found action had not been taken to support and protect a person appropriately following a fall.

Immediate action was taken by the registered manager to address this at the time of the inspection.

Staff understood about people's right to refuse care. However decisions about people's capacity and decisions made in their best interests were not always being reached or recorded within the framework of the Mental Capacity Act 2005 (MCA). Appropriate applications had been made under the Deprivation of Liberty Safeguards (DoLS), which helped ensure people's rights and safety were respected.

We have made a recommendation about the implementation of the Mental Capacity Act 2005.

Staff understood how to keep people safe from abuse. They understood how to report any concerns about people's well-being. Minor changes were needed to the home's safeguarding policy to ensure it reflected the local policies and procedures regarding investigation of concerns.

We have made a recommendation about seeking guidance on the procedure for investigation of safeguarding concerns to update the home's policy.

People were protected from the risks associated with staff recruitment. A full recruitment procedure was followed for new staff and there were enough staff on duty both day and night to meet people's needs. We saw staff being able to respond to people's needs in a timely way. People told us and we saw they had the skills, knowledge and experience to support people effectively. Staff told us they were well supported, and worked well as a team. They told us poor care was not tolerated.

The environment had been adapted to provide a comfortable home for people, some of whom were living with dementia. Each person had their own room, some of which had sea views. There were attractive level gardens, with wide pathways, adapted to meet the needs of people living with sensory impairments or dementia

People told us they enjoyed their meals, and we saw people eating well. The home's cook had a good understanding of people's dietary needs, and had information available to ensure people received their food in appropriate textures, for example to help people with swallowing difficulties.

People were supported by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect. Staff ensured they understood people's communication, and that people understood what they needed them to understand. People told us the home was friendly, and visitors were welcome at any time.

People's privacy was respected. Care took place in private, and people's dignity was supported. Staff understood the importance to people of caring for their appearance and dressing well.
People's needs and wishes regarding their care were understood by staff who ensured they were followed through. For example staff understood and respected people's wishes with regard to getting up early or going to bed late. People had good medical and community healthcare support available, including GPs, nurses, podiatrists, dental and optical services. Specialist healthcare, for example to support people with managing long term health conditions was available to people if they needed and wished for this.

People could take part in activities provided, or not as they wished. Since the last inspection the home had made efforts to provide more activities and be more flexible in their provision. On the day of the inspection there was a visiting singer, which people really enjoyed singing along with. In the afternoon people played games and quizzes. One person told us they liked to spend time in their room watching television. Staff understood and respected this. Other people had been going out more and staff told us how much they had enjoyed this.

Systems were in place for the safe management of complaints and concerns. People told us they had no concerns about raising any issues with the home's management.

People and others were consulted about their views on how the service could be improved. Questionnaires were sent out regularly to people living at the home, staff, relatives and other interested parties. Where suggestions were made these were considered and actioned where possible. Positive information was shared to support good practice.

The home had a set of written values and the provider told us these were regularly discussed to ensure they were shared across the staff team. The registered manager took advantage of learning resources to improve the home and develop their skills and knowledge. This involved attending courses and local forums, reading reports and journals and using the internet.

Records were well maintained, and safe systems were in place to ensure they were destroyed when no longer needed.

We identified a breach of regulations during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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 not always safe.

People were placed at risk of poor health outcomes because risks from falling or poor hydration were not always being robustly assessed or mitigated.

People were at risk of not receiving their prescribed eye drops safely because they had not been stored at the correct temperature.

People were not being protected from abuse because policies and procedures did not reflect the correct processes to be followed if abuse were suspected. We have made a recommendation about changes to the safeguarding policy and procedure.

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. There were enough staff to meet people's needs.

People did not always live in a comfortable clean, safe or well-maintained environment, and robust infection control practices were not always put into practice.

Is the service effective?

Good

The service was effective.

People were at risk of not having their rights respected, because the home were not following the best interests framework of the MCA. We have made a recommendation about this.

People were supported by staff who had the skills and knowledge to meet their needs.

People lived in an environment that had been adapted to suit their needs including people living with dementia.

People benefitted from good medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect.

People benefitted because staff ensured they understood people's communication. The home was friendly, and visitors were welcome at any time.

People's privacy and dignity were respected and supported.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff who ensured they were followed and respected.

People benefitted because staff were aware of the risks of social isolation and made efforts to engage with people throughout the day.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Good

The service was well led.

Changes had been put into place following the last inspection to make improvements and meet legislation. Where additional concerns were identified during the inspection the registered manager took immediate action to address them.

People and others were able to make changes at the home as they were consulted about their views on how the service could be improved.

People benefitted because the manager took advantage of learning resources to improve the home.

Good record keeping helped ensure people's needs were

understood and met, and the home was well managed.

Glenkealey

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. It was also planned to follow up on outstanding breaches of regulations identified at the previous inspection of the home in June 2015.

This inspection took place on the 19 October 2016 and was unannounced. The inspection team was made up of one adult social care inspector.

We looked at the information we held about the home before the inspection visit, including the inspection history, previous reports and information sent to us by the provider in a provider information return or PIR.

At the inspection we met with the provider and registered manager. We spoke with seven people receiving a service, six staff members from both day and night shifts, the home's training provider, a visiting healthcare professional and one visitor.

We also spent time observing the care and support people received, including staff supporting people with their moving and transferring and being given medicines. We spent two short periods of time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care or experiences.

We looked at risk assessments, minutes of meetings and feedback received and analysed from people using the service, staff and their relatives. We looked at five people's care plans and other records in relation to their care, including records of medicines administered. We looked at three staff files, including records of their training and supervision, and spoke with staff about the support they received. We looked around the home, looking at the environment and facilities for people.

Requires Improvement

Our findings

At the last inspection of the home in June 2015 the home had been in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations (Safe Care and Treatment). On this inspection we found that specific improvements had been made with regard to the unsafe elements of care identified at that time. These included improvements to previously incomplete medicines administration records and poor management of risky or distressed behaviours. However we identified other issues on this inspection that amounted to a repeated breach of this regulation.

People who were able told us they felt safe at the home. However, some people living at Glenkealey were living with dementia or mental health needs. This meant they were not always able to take steps to keep themselves safe, or might make decisions that would lead to risky outcomes for themselves or others.

The majority of risks to people were being managed well. However, we found improvements were needed in relation to how the home supported one person to manage risks associated with their health, with how one medicine was stored and to the safety of the environment.

One person had been identified as being at risk due to poor hydration. Staff told us the person was reluctant to drink, and their care records said "(person's name) does not drink much unless prompted to do so." The home's staff were recording the efforts made to support the person to drink, and we heard staff offering them drinks and trying to encourage them. However there was no record of the amount of fluid the person needed to maintain their health and well-being each day. The records we saw showed that one day for example the person was taking only 'sips' of juice or water over a 12 hour period, despite staff having tried to encourage them and offered them drinks on six occasions. It was not always possible to assess the amount the person had drunk as records stated "1/4 glass" or "1 small coffee" without detailing the exact amount. Records of fluids taken were not being totalled and no-one had oversight of these over several days. This meant no-one was monitoring how little fluid the person had taken in over this time. There was not sufficient information to judge the impact of their poor hydration on the person, and therefore assess the risks to their health and well-being. This placed the person at risk of poor hydration.

We looked at the records, risk assessments and management plans in place to help reduce the risks of people falling. Plans were in place to reduce the risks of people falling and suffering injury. The majority of risks to people from falling were being managed well. However, we found systems to manage or reduce risks from falling had not ensured that the risks to one person had been identified or managed well. When speaking with a person living at Glenkealey we saw they had a small cut and larger bruise to their forehead.

The person was living with a health condition that meant they were at increased risk of brain injury from the consequences of a head injury. The risks associated with their health condition and a head injury were not reflected in their management plan or falls risk assessment. The person told us they had fallen, but could not remember how. We looked at the records of falls, accidents and incidents, and saw that the record completed by staff in relation to the fall had indicated there was "no injury" to the person. The fall had been unobserved and had happened at night in the person's bedroom, four days before the inspection. There had been no referral for medical assessment of the injury either at the time or since the bruising had developed, as would be safe practice.

A staff member had completed a body map and the registered manager had 'signed off' the accident form two days after the fall, but there had been no investigation of the accident or how it could be prevented from occurring again. Once this was highlighted during the inspection a medical practitioner was consulted and a referral made to the safeguarding team at our request. This was because actions had not been taken to ensure their health and welfare following an injury. The registered manager updated us with information about their investigation and actions they had taken to prevent this happening again immediately after the inspection, which was in line with the safeguarding team advice.

People were not always being protected from the risks associated with medicines, because the home had not always followed manufacturer's instructions with regard to the safe storage of medicines. One person had been prescribed eye drops which needed to be kept refrigerated. The home had a medicines refrigerator and staff recorded the temperatures for this daily. However the temperatures being recorded differed widely from the temperatures needed to keep the medicines safe and effective to use.

People were not always being protected from risks within the environment. We found cleaning materials such as disinfectant cleaner left out in a bathroom. Prescription creams were left visible in people's en-suite bathrooms. These could pose a risk to people if accidentally misused Immediate action was taken to address this by removing them to secure storage. Some first floor window frames were in a poor condition, and the registered manager did not know if all low windows in the home, for example in the sun lounge contained safety glass as they had not been risk assessed. These could present risks if people fell against them. Fireworks were being stored in an unlocked cupboard in the laundry, which would be an area of the home at high risk of fire. The provider agreed to remove these.

People did not always live in a hygienic environment. In the laundry there was no clear workflow system, to separate clean and dirty laundry. This could lead to increased risks of cross infection. One bath hoist and a toilet frame had rust areas that meant they could not be kept clean and free from infection risks and there was a dirty toilet brush in one bathroom. An infection control audit had been carried out by the registered manager but had not identified these issues.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of medicines management were being managed safely. We saw staff giving people their medicines. We saw this was done with an explanation about what the person was being given and time for the person to take the medicine at their own pace. Staff told us they could tell from people's presentation if they felt they might need some pain relief, and there were pictorial records to help people explain any pain they had if they could not say this verbally. Staff had received training in the safe administration of medicines, and regular medicines management audits were carried out. Following the concern being raised about the fridge temperatures staff took immediate action to refer this to the local pharmacist to review the safety of the storage arrangements.

People received their medicines as they had been prescribed, and staff ensured that medicines were available to support people when they were needed. For example one person had painful dressings that needed to be done by community nursing staff. Staff ensured the person had prescribed pain relief before the community staff came to re-dress their legs. The person told us about this and how appreciative they were of the staff addressing this for them. Some people nearing the end of their life had medicines prescribed in advance of symptoms so that these could be used by district nurses as soon as they were needed. One person had 'as required' medicines prescribed to help manage anxiety or distress associated with a healthcare condition. There were clear protocols for this medicine to be used and we saw it had not been given to the person this month as it had not been needed.

Clear records were kept for the administration of medicines and where there had been any hand written changes to people's medicine administration records (MAR) these were signed by two staff to ensure their accuracy. We checked the stock balance of some medicines and found they corresponded with the stock records held by the home. We discussed the records for the administration of creams kept in people's rooms as the records had not always been signed to demonstrate prescription creams had been applied as prescribed. The registered manager was aware of this and was devising a system with staff to improve the recording.

Other risks to people, for example from pressure ulcers or moving and handling were being assessed and plans were in place to guide staff about how to reduce these risks. Staff were clear about people's moving and handling needs and there were no pressure ulcers. We saw evidence that other accidents and falls people had were managed well.

The home had followed a safe staff recruitment process. This included disclosure and barring checks (DBS) and obtaining a full employment history for the person. We spoke with one staff member who had recently been appointed. They told us they had received an induction programme even though they were experienced in care, and felt confident they had the skills and support to care for people. This was good practice and meant the home could ensure that although experienced, the staff member had the skills needed for their role at Glenkealey.

There were enough staff on duty to keep people safe and meet their needs. We saw staff supporting people throughout the day. Staff were calm and unhurried, and had time to chat, carry out activities or be flexible to meet people's changing needs. A visitor told us the staff responded quickly to their relation's needs. The registered manager told us they did not have a formal system for determining the number of staff needed on duty. However they were at the home daily working alongside the staff and the people living there and felt they would be aware if staff were struggling to meet people's needs in a timely way. For example they told us they would call in for extra staff to support if a person was at the end of their life and needed extra support. A senior member of care staff was always on duty and staff had access to the registered manager at any time if they needed advice or support.

Procedures to keep people safe from abuse were well understood by staff, however the home's policy and procedure needed changes to ensure that the home's management referred to the local safeguarding team before investigating any concerns raised themselves. We recommend the provider take advice from a reputable source on safeguarding procedures regarding the investigation of concerns.

Staff told us about how they would recognise and report any concerns over abuse, and told us they would not hesitate to do so. Staff had received training in adult safeguarding procedures.

We found areas of environmental protection other than those mentioned above were in place to ensure

people's safety. Regulators were fitted to hot water outlets and hot surfaces were protected to protect people from burns or scalds. People had individual evacuation plans in their files in case of fire, and the fire alarm systems were tested regularly. Staff told us they were aware of what to do in case of a fire and had regular updated training including evacuation procedures and using extinguishers. When we toured the home fire doors were closed except when held open by an approved device that automatically closed the door if the fire alarm sounded. Emergency information was available for staff in a "What to do if…" file.

No-one at the home needed full support with a hoist to move, but staff we spoke with were aware of items of equipment that people needed to help with moving and positioning, such as a stand aid and slide sheets. They told us they were confident in using them.

The provider told us the home had been without a maintenance person for the previous three months. They told us they had now recruited a person to this post and they would be addressing a list of maintenance and repair jobs at the home. Some rooms had a small odour problem, which the staff were working to address through increased cleaning and targeted cleaning products.

Good

Our findings

Some people living at Glenkealey were living with dementia. This meant they might need support making some decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff at Glenkealey were not always working within the principles of the MCA and code of practice. One person had been assessed as needing a soft textured diet due to swallowing difficulties. The person had dementia, and the registered manager told us the person was not very happy with eating pureed food. The person's care plan stated that "To ensure we are protecting (name of person) it was deemed safer to follow a modified diet." However there was no record of the person's capacity to consent to this change having being assessed, or any best interests meeting with their advocate and others having being undertaken. This was not in line with the 'best interests' framework of the MCA. Another person was receiving their medicines covertly, disguised in their food, because they had previously been refusing to take them. The home had sought agreement from the person's GP to do so. But there had been no assessment undertaken by the home or others in relation to the person's capacity to refuse medicines, or a best interests decision making process involving family members or others acting for them. Involvement of the person and consultation with relatives (and others as appropriate) is an essential part of best interest's decision making under the MCA.

The provider and registered manager are recommended to take advice on the implementation of the Mental Capacity Act 2005 and Code of practice with regard to the assessment and recording of 'Best Interest' decisions.

We did not find that any of the decisions that had been made were overly restrictive or unlikely to be in the person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the last inspection of the home in June 2015 the home had been in breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations (Safeguarding service users from abuse and improper treatment). This was because people

were being unlawfully deprived of their liberty as authorisations had not been sought under DoLS. On this inspection we found improvements had been made. Applications had been made for authorisations to deprive people of their liberty at Glenkealey if they were unsafe to leave the home without staff support and supervision. None of these had been granted yet due to delays at the local authority.

Staff were aware of people's rights to refuse support and how they made or communicated decisions, and this was described in people's care plans. For example, one person's plan said "(Person's name) has difficulty in expressing her needs, but staff should continue to offer choices and seek permission from her". We heard this person being supported to get up by staff, and being offered choices, such as where they wanted to go and what they wanted to eat. Staff told us how they supported people who were reluctant to receive care. They said they would leave people and then go back a bit later, or ask another staff member to try to assist the person. One told us "It is difficult sometimes. We know we have a duty of care and we want to help people. We need to see it from their side".

People were supported by staff who had the skills and experience to understand and meet people's needs. Some staff had worked at the home for over 20 years, and provided consistency and stability in the staff group. There was a training and development matrix for the home, to ensure updates in essential training were provided in a timely manner. The training provider for the home told us about the different types of training available to support different staff learning styles and to quickly identify any staff competencies that were not up to the required standard. Staff also told us they had received a full induction training, including working alongside more senior staff for a fortnight when they started. Staff files contained copies of certificates staff had achieved and some staff had undertaken training at previous work places that meant they had the skills they needed. Learning was assessed through observations of staff competency, which were recorded in staff files, and followed up in regular one to one meetings. Formal supervision was carried out which identified any training needs, workplace issues and ideas for improvement. A visiting community professional told us staff were always well informed when they visited and they had "no concerns" over their skills or competency.

People received the support they needed from community support services such as dentists, podiatrists and opticians. People's files contained information about any healthcare or well-being issues and any treatment recommended. People had access to specialist support staff, such as specialist nurses to manage health conditions. Where professional advice had been given we saw it was followed through, for example with supporting the person with food supplements. Some of the people living at Glenkealey were living with dementia, and needed support from staff to help reduce risks to themselves or others from any distressed or anxious behaviours. We saw evidence the home consulted with healthcare professionals such as community mental health nurses for advice on how to support people positively. Guidance had been provided to staff on how to intervene to support people's distress or reduce risks to their care.

People's care reflected professional advice given. For example, people were weighed regularly (monthly) and where there were concerns appropriate referrals were made to medical or other professionals. One person had been losing weight. They had been referred to a community dietician and prescribed dietary supplements. The dietician had asked the person be weighed fortnightly and we saw this had been done. The person had gained weight and the supplements had been discontinued on the GP advice.

Where people were living with a long term health condition information about this was in the person's file. This helped ensure staff were aware of the signs of any potential change or deterioration in the person's condition.

People told us they enjoyed the meals served to them. One person said "Just what I like. I always eat well.

We all do. And I do love a cup of tea at any time". We asked them if they could ring for a cup of tea in the night and they said they believed they could but had never tried. One person told us they had "no appetite at present". We saw they had a drink and a call bell within easy reach. We heard staff tell the person they would be up soon with a snack and a cup of tea. The person's file showed staff tried to encourage them to eat. Their file said "(person's name) generally eats best at breakfast….will verbally refuse food as soon as it is mentioned to her, but if in the right environment with the right support (person's name) will begin to eat". We spoke with the home's cook about the meals and choices prepared. They had a good understanding of the different diets and textures of meals to be prepared, and of the importance of attractive presentation in encouraging people to eat. At the time of the inspection the home was providing specialist diets for people with coeliac disease, diabetes and soft, pureed or fork mashable texture diets.

People had free access around the home, although some people would need staff support to access some areas due to short flights of stairs and chairlifts. There was a main lounge and sun lounge where people could sit and a large dining room. We saw people chose to spend time in each of these areas throughout the day. One person told us how they liked to spend time in the sun lounge reading their daily paper. We saw they did this before lunch and enjoyed it. All areas of the home seen were warm and comfortable. People were able and encouraged to personalise their own rooms if they wished. One person's room for example was very attractive and homely, with evidence of hobbies and crafts they enjoyed on display. Another person's room was more basic but contained items that were very personal to them which they told us about. Advice had been sought about safe garden design and people had access to a safe level front garden area, with some provision for people living with dementia. This included a 'bus stop' seating area and memory prompts, such as signs with the home's name.

Some other environmental adaptation had taken place to support people with dementia or memory loss to orientate themselves around the building. People's rooms were identified with their name and there were pictures and signs on toilet and bathroom doors to help people understand where these rooms were. Some directional signs were also in place, for example "This way to the toilet" which helped people with memory loss locate these facilities.

Good

Our findings

People and visitors told us they were supported by kind and caring staff. People said "Staff are very caring – always caring, very nice, very kind", and "Staff are very nice, it's a friendly place". A visitor said "No concerns… the family are very happy". They told us they were free to visit the home at any time, and always felt welcomed when they came. We saw they were on first name terms and had a friendly, open relationship with staff.

Staff told us they were happy with the standards of care at the home, and would be happy for a relation of theirs to be cared for there. One told us "I always tell the staff you need to look after them like it was your Mum, grandma or yourself".

People were supported by staff who had a cheerful and positive manner when talking to them. Staff took time to understand and support people's communication. Appropriate language was used and where people had difficulties communicating, staff reflected people's speech back to them to ensure they had understood what the person wanted. We saw staff spent time trying to ensure people understood what they were saying to them, and gave them sufficient time to process the information and respond. For example we saw one person was being supported by staff to transfer around the home. Staff discussed with them each step of the transfer into a wheelchair from a chair to ensure they felt re-assured. The transfer was done at a slow pace. The person was encouraged to maintain some independence and do some parts of this themselves. People's privacy was respected and care was delivered in people's rooms. If people needed assistance, for example to go to the toilet this was given discreetly.

Staff demonstrated a good understanding of how to communicate with people. One person's care plan indicated that communication with them was best had in "simple closed questions" as this helped with their understanding and ability to respond. We heard staff speaking with this person and saw that their language was simplified which helped the person respond and understand what was being asked of them. This helped reduce any confusion or frustration. One person became quite vocal during the afternoon, and we saw staff chatting with the person to help distract and engage them. When not in the person's room with them they regularly passed and spoke with them, which helped reduce any risks of the person becoming socially isolated. Another person told us they liked their own company and did not want to leave their room. They told us this was respected, but staff kept popping in to check on them so they did not feel alone.

Information about people was kept securely, in the home's office. We saw some people's plans contained information about their social and personal history. This was used by staff to help them understand people's

behaviours and choices in the context of the life they had led. Staff were aware of people's history and its significance. When we spoke with staff about one person's room they could tell us about the importance of certain items in the room to the person, and what they meant to them. In another person's room we saw that family photographs had been labelled with the names of the people in the photo and dates, so that they could be used in discussions with the person.

People were able to have a say in the running of the home through resident's meetings and giving direct feedback. The minutes of the last meeting showed this had focussed on "did people feel safe" at the home, food choices and activities people might like to do. One person we spoke with told us they were happy to speak with staff or their relatives if they wanted something changed about their care. They told us "I say what I think".

People were treated with respect. In records we saw comments were respectful. Staff took time to ensure people's clothing was co-ordinated and accessorised where people needed help to manage this, and attention had been paid to people's hair and fingernails. The registered manager told us "we have regular pampering sessions". The registered manager encouraged staff to see the world from the perspective of the person being cared for. One staff member told us they had been hoisted using the homes moving and handling equipment to help them understand what it felt like from the person's perspective. They told us it had made them think more about the person and their experiences of care and how frightening this could be. Staff had received training in equal rights and diversity to help reduce any discriminatory practice.

Some people had chosen to express a wish not to have active medical interventions in the case of sudden deteriorations in their health, such as resuscitation. Their wishes were recorded in their care files as an advanced directive and had been shared with GPs and families. GPs had in some instances discussed people's wishes regarding treatment escalation with their relatives, and copies of their records were also held on file. This helped ensure staff were clear about the actions to take in case of a sudden deterioration in the person's condition.

Good

Our findings

At the last inspection of the home in June 2015 the home had been in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations (Person centred Care). This was because people had not been provided with opportunities to engage with meaningful activities that met their need and interests.

On this inspection we found there had been improvements. People at the home had opportunities to take part in activities that met their wishes. The registered manager told us since the last inspection the home had worked on developing more individual and person centred activities as well as organised group ones. This was in part because of the differing needs of the people living at the home, and because they wanted to ensure activities were flexible and open to everyone. For example, one person had recently been out on the bus to Dawlish where they used to live, and another person had enjoyed being taken out using a wheelchair. On person was being encouraged to knit some squares for sensory cushion covers to help engage people living with dementia and give them something to hold and handle. Another person was being encouraged to draw. Some people who were living with more significant dementia had dolls or other sensory items to interact with. Regular external activities were provided, and staff had allocated time and resources to help support these. On the day of the inspection we saw and heard a new musical activity being trialled. This proved very popular with people joining in and singing along to requests. In the afternoon there was a quiz and skittles game run by a staff member. One person told us "I do what I like. If I want to do it I will and if I don't well there you go."

Care files showed each person had an assessment before they moved into the Glenkealey, to make sure the home could meet their needs and expectations. Assessments in people's files included information from previous care home or hospital placements, relatives and the person themselves where this was possible. People we spoke with were not able to remember being involved in developing or reviewing their own care plans, but were happy that the staff would support them in the way they wanted. One person told us "Staff are always writing their notes. They write down when I go to the toilet. It makes me laugh". A relative told us they were not involved in reviewing their relation's plan as their relation was able to say themselves what they wanted.

People's care was delivered in accordance with their plans and reflected their wishes. Plans included information about people's preferences for drinks and daily routines. When we arrived at the home at 6.50am two people were already sitting in the lounge. They both told us they liked to get up early. Staff provided them with a cup of tea and then breakfast. We spoke with one person who told us they liked to go to bed early, around 7pm. They said "I'm ready by then and I like to rest my legs". A staff member told us that

the person refused to put their legs up in the afternoons as requested by the district nurses, so "as soon as she is ready staff put her to bed". Daily care records showed other people liked to stay up until late at night watching television.

The Provider Information Return (PIR) completed by the registered manager told us "Our care plans are ever evolving with our clients, aiming to ensure that they are accurate and kept up to date with a person's needs and preferences. By asking for feedback from staff by supervision and in team meetings we can ensure that the care plan documentation is relevant and act on any concerns staff maybe having". Where there had been changes in people's needs their plans were reviewed and updated to reflect their new needs, for example for increased support, or increased independence. Plans covered all areas of need, from moving and handling, pressure relief to emotional support, and were reviewed regularly. They contained sufficient detail to enable staff to support people's independence and to offer assistance in the way they preferred.

People told us their lifestyle choices were respected. For example one person told us they liked to spend their time in their room. They said staff tried to encourage them to go into the lounge occasionally but they did not want to do so and this was respected. The person said "I've got my telly, I'm happy". Records showed the person had enjoyed making and icing cakes before coming into the home and the person said staff ensured they were made aware of cookery programmes on the television they would enjoy.

The complaints procedure was on display in the home, and records were kept of any concerns raised and the home's response. The registered manager ensured complaints were acted upon promptly and a response sent to the person with an apology or an indication of actions to be taken to prevent a re-occurrence if needed. People and a relative told us they knew who they would raise any concerns with, and they felt confident to do so. One person told us "Why would I want to complain? If I was unhappy I would tell (name of staff member) and they would sort it out."

Good

Our findings

Glenkealey had been inspected on 4 and 8 June 2015, when they had been rated as Requires Improvement overall. There had been breaches of Regulations 9 (Person centred Care), 12 (Safe Care and Treatment) and 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found that actions had been taken to address the concerns identified at that time. For example we found that care plans contained more 'person centred' information about how people wanted their care to be delivered and previous lifestyle choices, and more activities were being provided. This had improved the ratings for the key questions for effective, responsive and well led, and the overall rating for the home.

Regular audits were being carried out by the registered manager for example for infection control practices, risks within the environment and medicines management. We identified some safety issues that had not been identified with all of these systems. In their PIR the registered manager had told us they were seeking to refine their audit tools to improve their effectiveness. Many areas were addressed immediately during the inspection and the registered manager followed up immediately after the inspection with details of actions they had taken to ensure there was no re-occurrence.

Where other risks had been identified systems were in place to manage them, for example ensuring staff had clear and consistent guidance from community professionals to help them support people with risky or distressed behaviours.

People were protected because there were systems in place to ensure any errors in medicines administration were reported and lessons learned. We spoke with one member of staff who had made a medicines error. This had been reported immediately, and no harm had occurred to the people involved. The staff member told us "That will never happen again" and that lessons had been learned. Information about the incident had been shared amongst staff to ensure it was understood what had gone wrong, and this was included in training for staff in safe medicines management.

The home had a registered manager in post. The registered manager worked alongside staff and as such knew people well. They held regular team leader meetings to keep the staff team in touch with people's changing needs and changes at the home. They attended local forums with other care managers, read reports from other services and specialist care journals to update themselves on best practice. They told us in their PIR that "Our service has a management team in place that have been working together for nearly five years. In this time we have built relationships to support each other." They had attended meetings such

as "Proud to Care" campaign, and told us they were "always asking questions" for example from visiting specialist nurses. This showed us they were keen to keep their knowledge and skills up to date.

People benefitted because there was a shared understanding of the purpose and values of the home. The service promoted a positive culture, and staff and management worked consistently to support people. The provider showed us they had a written set of core values that were shared among the staff team at team meetings, and re-enforced through supervision. The provider told us they aimed to demonstrate these in practice every day, and they were aimed at "offering the best care that we possibly can". They included values such as integrity, teamwork and excellence. A recent team meeting had included topics such as positivity and negativity in the workplace and team working to help ensure these values were embedded in practice.

Staff demonstrated a commitment to high standards of care and doing the 'best they could' for people. They told us they respected the home's management and felt they were approachable. One said they had "good support" and that they could call on the registered manager or a team leader "at any time" for advice and guidance. Staff told us they worked well together, and the registered manager and team leaders were strong role models and 'didn't miss anything'. A team leader told us about how they worked with staff to help develop their skills, including practical demonstration and observation until they were clear they understood how things should be done correctly. They told us they had no concerns about challenging any poor practice. Handovers between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

People benefitted because the service monitored the quality of the care delivered through quality assurance and quality management systems. Questionnaires were sent to relatives, visitors and visiting professionals to gather their views about the operation of the home. Following the return of the questionnaires the results were analysed and an action plan drawn up. Recent questionnaires seen that had been sent to visiting professionals had provided positive responses about the home being "approachable". Questionnaires were due to be sent out again to people living at the home and their relatives. These were due to be themed, looking at the quality and choice of meals available. The registered manager valued feedback and acted on suggestions made. For example the registered manager told us that staff had been identifying issues with the medicines supplier. A meeting was held with the supplying pharmacy and changes made to ensure safer systems for the supply of medicines were put in place. Changes were made as a result of concerns identified, and the manager was aware of the 'Duty of Candour' in relation to being open and transparent with people about where there had been incidents involving their care..

The records we saw were well maintained and up to date. Care plans, policies and procedures were available to staff in the home's office. There were safe facilities for storage and disposal of records. Notifications had been sent to the CQC about specific incidents at the home as required by legislation.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people were not always being assessed. The home had not taken all reasonably practicable actions to mitigate risks to people. The provider had not ensured the premises were safe. The provider had not ensured proper and safe systems for the storage of medicines were in use.