Care Quality Commission

Tamaris Healthcare (England) Limited

Regents View Care Home

Inspection report

Francis Way
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

Regents View Care Home provides nursing and personal care for older people some of whom have dementia care needs. The home is registered for 50 places but there are only 48 bedrooms following the conversion of two rooms for storage. The home is located in Hetton-le-Hole close to shops, amenities and public transport. All bedrooms are single occupancy and have en-suite facilities. The home has two floors of accommodation which are served by a passenger lift. At the time of this inspection there were 45 people using the service.

This inspection took place over two days. The first visit on 2 December 2014 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 3 December 2014.

The last inspection of this home was carried out on 30 July 2013. The service met the regulations we inspected against at that time.

The home's registered manager had recently resigned. At the time of this inspection a peripatetic manager was temporarily covering the manager's post until a new manager could be appointed. A registered manager is a

Summary of findings

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.

Some parts of the premises were not been well maintained. Bathrooms and toilets were in a poor state of decoration, armchair covers were torn and flooring was marked and stained in some areas. Some areas of the premises were not kept clean. This compromised the control of infection as well as the dignity of the people who lived there. Over the past year staff had had very few opportunities for supervision meetings with a supervisor. This meant they had not had sufficient support in the development of their role.

People and their relatives were positive about the service. People said they felt safe and comfortable at the home. Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. Potential risks to people's safety were assessed and managed. People's medicines were managed in a safe way.

There were enough staff to meet people's basic care needs. The use of agency staff had reduced, so people were cared for by familiar staff. The provider recognised that more staff were needed to provide therapeutic care for people and these posts were advertised. Staff were recruited in a safe way so that only suitable staff were employed. Staff received the training they needed to be competent in their roles.

Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and deprivation of liberty safeguards to make sure they were not restricted unnecessarily. People's safety was protected without compromising their rights to lead an independent lifestyle.

People who used the service and their relatives told us they felt well cared for in the home. People were supported to eat and drink enough to meet their nutrition and hydration needs. Any changes in people's health were referred to the relevant health care agencies. The health care professionals we spoke with felt the home responded in the right way to any changes in people's needs.

People were treated with respect and dignity. People, relatives and visitors described the staff as "caring and compassionate", "angels" and "kind". There was a warm, friendly atmosphere in the home and there were positive interactions between staff and the people who lived there.

People and their relatives were asked for their views about the home at meetings and these were now being used to improve the service. People had information about how to make a complaint or comment and these were acted upon. People, family members and staff felt they could approach the peripatetic manager at any time and said she was "helpful" and "supportive".

The provider had a quality assurance programme to check the quality of the service. However shortfalls that had been identified by the quality checks, such as the poor state to bathrooms, had not always been acted upon.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe. One shower room was unsafe and two bathrooms could not be used because they did not have any equipment to help people to use the baths. The bathrooms were in a poor state of decoration.

Some parts of the home were not clean. Bathrooms were hard to keep clean because of the poor surfaces. Sometimes there was only one member of cleaning staff on duty which was not enough for this large home.

People said they felt safe and comfortable with the staff. The provider made sure only suitable staff were recruited. People and relatives felt there should be more staff to help people on the first floor. The provider agreed and was trying to recruit more staff. Staff managed people's medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not had regular supervision sessions or annual appraisals so had not been supported with their professional development.

People felt their needs were met and were positive about the support they received from staff. People were supported to eat and drink enough to maintain their nutritional health.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

Is the service caring?

Good

The service was caring. People said staff were kind and friendly. Relatives said staff looked after them as well as the people who lived in the home.

People were supported by calm and attentive staff. People were supported at their own pace. Staff were patient and gave encouragement when assisting people. Staff talked to people in a warm, friendly way.

People were encouraged to make their own choices. People were treated with dignity and respect. Staff spoke about people in a valuing and positive way.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their individual needs. Staff were familiar with each person and knew how to support them. People's care records showed the most up-to-date information about their individual needs, preferences and risks to their well-being.

There were activities for people to participate in, either individually or in groups, to meet their social care needs. The home had plans to improve activities and therapeutic support when the staffing increased.

Summary of findings

The service dealt with complaints that had been made. People knew how to make a complaint or raise a concern. People told us that they were able to make everyday choices.

Is the service well-led?

Requires Improvement

The service was not always well led. People's safety was monitored and the provider checked the quality of the care at the home. However, relatives and managers had identified shortfalls in the quality and safety of the bathrooms and toilets but these had not yet been addressed by the provider.

People, visitors and health agencies were positive about the way the service was now being run. The home did not have a registered manager because they had left. The home was temporarily being managed by an experienced relief manager.

People felt there was an open, welcoming and approachable culture within the home. Staff said they felt well supported by senior staff and the relief manager.

Regents View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 December 2014 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist adviser and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second visit was carried out on 3 December 2014 by an adult social care inspector which was announced.

We spoke with 12 people living at the home and 11 relatives and friends. We also spoke with the peripatetic manager, a regional manager, two nurses, five care workers, two cleaning staff and a member of catering staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of four staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also joined people for a lunchtime meal to help us understand how well people were cared for.

Before our inspection we reviewed the information we held about the home, including the notifications of incidents that the provider had sent us since the last inspection. We contacted the commissioners of the service and the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. During and after the inspection we asked a range of health and social care professionals for their views about the service provided at this home. These included a community nurse and a dietitian.

Inadequate

Is the service safe?

Our findings

People who lived in the home were not always safe because some parts of the premises were in a poor state and they were not always protected against the risk of infection. Staff told us, and records confirmed that the home's maintenance member of staff carried out health and safety checks around the premises, including fire safety and hot water temperature checks. However there were a number of premises shortfalls that compromised the health and safety of people and staff. There was a shower room and two bathrooms on the ground floor, but neither of the baths could be used by people because they did not have lifting equipment. On the first floor there were two showers and two assisted baths. One of the shower rooms had a large exposed hole in the wall and there was no cover for the drain in the floor so this was a tripping hazard for people. The regional manager decommissioned this room during our visit. This meant there were only two bathrooms and one shower room for the 48 places at the home.

Some extractor fans in bathrooms and toilets were switched off. The extractor fans in bathrooms had not been checked as part of the routine maintenance checks. Some extractor fans were furred with debris which could compromise fire safety. One communal toilet had a broken lock which would compromise the privacy of people using this room. One of the two dryer machines in the laundry had been broken for several months. As a result wet clothes were stacked in baskets waiting to be dried. Some areas of the home had scuffed walls and stained carpets. The armchairs in the first floor lounge had torn covers. In this way the provider had not made sure that the premises were well maintained for the people who lived there. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were a number of cleanliness shortfalls that compromised the control of infection within the home. Some bathrooms had an unpleasant odour. Some protective gloves had been placed in unlined pedal bins instead of specific clinical bins, and some clinical bins were not operable because the foot pedal was broken. There were brown stains under the shower chairs in two shower rooms, and brown grime around the base of some toilet pedestals. Most surfaces in the bathrooms were scuffed or permeable so were difficult to keep clean. Some wall areas in toilets and bathrooms had exposed plaster. All the light pull cords to bathrooms and shower rooms were grubby. The exposed drain cover in one shower room on the first floor was filled with stagnant water. There were clean towels placed on the floor in one bathroom and clean towels placed on a dusty plastic box in a shower room. The wooden handrails in the lift had worn paintwork which meant these surfaces were porous and could not be fully cleaned. This meant the provider had not made sure the premises were kept clean and hygienic for the people who lived there. The provider was not meeting criterion 2 of the Code of Practice on the prevention and control of infections (which is the Department of Health guidance on good infection and prevention control). This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff rotas showed that there had been only one domestic staff member on duty for three out of the seven days during the week of this inspection (another housekeeping staff member was on laundry duty). This was not sufficient to meet the cleaning schedules required at this large home. The peripatetic manager explained that staff were covering vacant posts and the urgent leave of other staff, which had had a knock-on effect on domestic hours during this week. The peripatetic manager had taken on the role of designated infection control lead and had begun to audit and address the cleanliness in the building. The domestic staff had now taken responsibility for checking and cleaning mattresses and checking the hygiene practices of individual members of staff on a monthly basis.

Many of the people who lived at the home were living with dementia so found it difficult to express a view about the service they received. The people who were able to comment told us they felt safe living at the home and with the staff who cared for them. Relatives also commented positively on the safety of their family members. One relative said, "My mother had recently shown increasingly challenging behaviour and it is wonderful to have her in such a safe and caring place."

Staff had a good understanding of how to respond to safeguarding concerns. All the staff we spoke with said they would not hesitate to report any allegations or incidents of abuse. Staff were able to describe the different signs of abuse and knew how to raise any concerns immediately. Staff told us, and records confirmed, they received training

Inadequate

Is the service safe?

in safeguarding vulnerable adults. All staff, including ancillary staff, had access to on-line training in safeguarding adults which they were required to complete at least annually. The training records showed that 91% of staff had completed safeguarding adults training within the past year. All the staff we spoke with were familiar with the whistleblowing policy and procedures and felt confident in reporting any concerns they may have.

Risks to people's safety and health were assessed and recorded in each person's care files. There were risk assessments about people's potential for falls, pressure damage to their skin and using moving and assisting equipment. The risk assessments were reviewed each month. The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed.

People and relatives said there had been a major improvement since the peripatetic manager had been appointed and almost no use was now being made of 'agency' staff, which had been a concern over recent months. Many of the staff had worked at the home for a number of years and there was clearly good teamwork and a cooperative attitude across all levels.

Relatives said the quality of staff was good and people's basic care needs were met. However they felt it was sometimes difficult to find staff on the first floor. One relative told us, "It's safe, but there should be more staff on the first floor. If a staff member has to come down to get medication or fill in records it only leaves a couple of staff to manage everyone else." Another relative commented, "There's often no staff to be seen upstairs because some people need two staff to help them and they might be in their bedroom or a bathroom."

At the time of this inspection the staffing levels comprised of two nurses and seven care workers through the day, and one nurse and three care workers through the night. The peripatetic manager described a new staffing tool, called CHESS, that had recently been introduced by the provider. The new tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing staffing hours required throughout the day and night. The new staffing tool indicated that the home required an additional staff member on duty during the day and an additional staff member during the night. The regional manager agreed that the staffing tool had identified the need for more staff and that new staff were going to be appointed to these posts. This would also allow staff to spend more therapeutic time with people, as currently much of their time was task-orientated.

We looked at the recruitment records for four staff members and spoke with staff about their recruitment experiences. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

Some staff had worked at the home as relief staff for several years and had then chosen to work there permanently. Some staff members who had left the home to work elsewhere had been happy to return. One staff member told us, "I worked here before and couldn't wait to come back. It's a good home and very good teamwork."

The arrangements for managing people's medicines were safe. Medicines were securely stored in a locked treatment room. Only the nurses on duty held the keys for the treatment room. Medicines were transported to people in locked trolleys when they were needed. Staff gave people the support and time they needed when taking their medicines. The lunch time medication round was observed in the first floor dementia unit. The round was conducted professionally and systematically, however even for a short round it was a lengthy process as the nurse waited for people to be taken to the dining room before administering the medicine.

Records about the administration of medicines (MARs) were accurate and up to date. Each person was clearly identifiable on their MARs and any known allergies were recorded on the front of their medicine chart. A staff signature verification sheet was in place to show which staff members were responsible for administering medicines. There were protocols in place for 'as and when required' medicines with evidence of reviews taking place. Medicines that were not needed were disposed of safely.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider supported the development of staff through supervisions. Supervisions are regular meetings between a staff member and their supervisor, to discuss how work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. It was evident from supervision records that most nurses and care staff had had only one or two supervision sessions in the past year, which was contrary to the provider's own supervision policy. Some night staff had had no supervision sessions with a line supervisor in the past year. One of the nurses had not had any clinical supervision for 11 months. This meant the provider had not made sure that the professional development of staff was supported or assessed. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives said they had confidence in the skills of staff to meet people's needs. One relative told us, "I call in daily and the staff are brilliant. They do everything we want them to do." Relatives felt staff understood people's needs and supported them in the right way. One relative commented, "Several staff have been here for years so they are familiar with people's needs. The quality of care is very good."

In discussions all the staff we spoke with felt "supported" by the peripatetic manager and the provider. There was clearly good teamwork between staff members and a good mix of experience and skills. There was at least one registered mental health nurse (RMN) on duty each day, which was appropriate for this home as several people were living with dementia. Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer based training system for each staff member to complete annual training courses, called e-learning. The home provided care for people living with dementia and staff spoke enthusiastically about group training they received in dementia care. All care staff, except new staff, had a suitable care qualification such as a diploma in health and social care. The activities co-ordinator had a national qualification in activities for people living with dementia.

The peripatetic manager was developing an annual training plan for the registered nurses to complete. This included updated training in using syringe drivers, catheter care and pressure ulcer prevention.

New members of staff received induction training. The new starter we spoke with felt their induction was comprehensive, with two days introduction to the service and a two week supernumerary period where they were mentored by experienced staff. Since commencing work the new starter had completed their mandatory training, registered for their diploma in care and had plans to go onto a dementia care qualification.

One staff member told us, "Quite a few of us have worked here for many years. It's a nice home to work in and very friendly." Another staff member commented, "I would work any shift they asked. We all help each other out to make sure we're helping the people who live here."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The senior staff were aware of the recent supreme court decision about DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. The home staff had made seven DoLS applications to the local authority in respect of people who needed supervision and support at all times, and further applications were to be made. This meant staff were working collaboratively with the local authority to ensure people's best interests were protected without compromising their rights.

The peripatetic manager and staff were clear about the principles of the Mental Capacity Act 2005. There were assessment records about the capacity of individual people to make their own decisions, and records of best interest meetings where they did not have capacity to do this. For example, one person was receiving medication in a covert way. There was a recorded mental capacity assessment and best interest decision about this. However the current record about this had only been signed by a nurse from the home and did not include the signature of the person's GP and relatives to show their involvement (staff said the original record with signatures would have been archived). Staff agreed to make sure the record was signed by the GP and relatives as soon as possible.

Requires Improvement

Is the service effective?

The home had achieved the bronze standard of the PEARL Accreditation Scheme. PEARL stands for Positively Enriching And Enhancing Residents Lives. The PEARL programme is an accreditation programme specifically designed by Four Seasons Health Care to ensure that services are providing the most up to date training, communication and interventions for people living with dementia. There were lots of items of visual and tactile interest for people around the home, such as themed areas and reminiscence artefacts. Some corridors had collages of local scenery, such as former coal mines. There were memory boxes outside bedrooms for people to recognise their own room. There were visual signs for different rooms and coloured doors to bathrooms and toilets for people to find their way around. There were sitting areas in corridors so people could have a rest stop if they were walking. There was easy, level access to a secure, well-maintained garden from the ground floor lounges. This meant the home had some specific design features that supported people with dementia.

People said they were satisfied with their meals. We joined people for a lunchtime meal. The meal was tasty, plentiful and hot. There was ample supply of hot and cold drinks and plenty of napkins were available. There was a choice of meals and people were asked for their preferences a few hours before their meals. On the first floor there were pictures of different dishes to help people make their choices (although one picture did not reflect the actual meal so this could be confusing).

Staff supported people with their meals and drinks in a sensitive and appropriate way. Nobody was left waiting for anything. Special cutlery was provided and a number of people managed their meal independently or with minimal assistance.

On the first floor the smaller size of the dining room meant that meal times were held over two sittings. Some people dined in their bedrooms. The meal trays for people in their bedrooms were set out with a doily and salt and pepper pots. Tables were set with cloths and all the meals served looked appetising. A choice of two main meals and desserts were offered. Staff were observed to support people in a professional manner and engaged with them appropriately making the event a social one. In spite of the level of activity and degree of dementia of a number of people, the dining area was quiet and convivial which was attributable to the calm, professional support provided by the staff.

Some people had nutrition care plans and choking risk assessments where this was appropriate and there was evidence of SALT (speech and language therapy) involvement. Food intake and fluid balance charts were recorded for people, where required. Several staff had recently attended training in dysphagia (swallowing difficulties) and felt confident about supporting people in the right way with drinks and foods. The catering staff had a list of people's dietary needs, and were knowledgeable about how to prepare soft or pureed foods if people required this. A dietitian told us that only a few people had been referred to them by the home. However they commented, "The home appears to be proactive in providing the fortified diet, plenty of nutritious choices (puddings and snacks). Staff follow advice given from dietitian assessment."

Relatives told us people were supported with their health care needs at the home. Throughout the care records we viewed there was evidence of involvement with other health and social care professionals. The home was part of a local community health care pilot, called the Coalfield Initiative. The initiative aimed to improve primary care and nursing care in care homes and to reduce admissions and readmissions to urgent care. As part of the pilot a local GP and community nurse visited the home every week to check people's health care needs. This helped to ensure people received timely support with any changes in their health, which could also help to prevent some admissions to hospital. The visiting community nurse told us, "The staff act on advice and ask for help if it's needed, especially for any health changes."

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. One person told us, “The staff here are wonderful.” Another person described staff as “angels”. A relative commented, “Staff are very good. They are very engaged with people.” Another relative told us, “We visit frequently and staff always appear caring and compassionate.” Relatives were also positive about the kind attitude of staff towards others. One relative told us, “As well as caring for my [parent], they have cared for me and helped me.”

In discussions staff spoke about each person in a valuing and positive way. All the staff on duty that we spoke with were able to describe the individual needs of people who were using the service and how they wanted and needed to be supported. Throughout this visit we found staff chatted to people in a friendly way and included them in conversations and decisions about their day. A community nurse told us, “At all the times I’ve visited, staff have acted appropriately towards people, visitors and visiting professionals.”

People were assisted by staff in a patient and friendly way. People had a good rapport with staff. Staff knew how to support people with their behaviours and understood people needs when they were not always able to articulate themselves very well due to their dementia. We saw people were comforted and reassured by care workers when this was required.

People were encouraged to make their own daily decisions wherever possible. The care records showed that people were prompted to make choices about when to get up and go to bed, what to have for meals and what to wear. People were supported with their personal appearance. Some people enjoyed pamper sessions by young people on work experience who were ‘doing their nails’.

Some people had care needs which meant they occasionally needed guidance from staff with everyday choices. Staff gave people all the time they needed to express their choices and wishes. We saw support was carried out at a person’s own pace so people were not rushed.

Staff commented positively on the friendly, warm atmosphere in the home. One staff told us, “I would be happy to have my parents live here, so that shows how I feel about the care here. It’s a really friendly home.” Another staff member commented, “We’re like a big family – residents, staff and relatives.”

People were treated with respect and dignity. People told us their requests for privacy were acted upon. For example, one person commented, “Nobody bothers me if I ask for that [privacy], but they come at once if I want them.” Relatives commented that people received gender-appropriate support with their personal care. For example, one man showed that he preferred male care workers to assist him with showering and this was respected.

Relatives said they were consulted over care reviews and kept informed about care plans where this was appropriate. The peripatetic manager encouraged as much input from families as possible. There was regular telephone contact between the home and relatives in the event of any changed conditions and family were made welcome to call at the home at any time.

Relatives had been asked by the peripatetic manager if they would like to take part in a ‘compassion in care’ project at the home. Two relatives had subsequently become the ‘link’ people between relatives and the home. It was good practice that they were going to be involved in carrying out checks of how people were supported with their dignity and checks of the dining experience for the people who lived there.

Good

Is the service responsive?

Our findings

People who were able to express a view told us the staff acted on their requests and knew their individual preferences. One person told us, "I like my room very warm and they always make sure it is." People told us staff were always 'polite' and ensured that they were happy about any support they were going to receive.

People had care plans that set out their individual needs and how they required assistance. In the eight care records we looked at it was clear that people's individual needs had been assessed before they moved to the home. The assessments were used to design plans of care for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs.

The care plans were sufficiently detailed about people's individual needs, although some would benefit from more guidance for staff about how to support those needs. For example, some care plans had good details of people's resistance to care and said they could be alleviated by using different communication and distraction strategies. However the care plans did not explain what those strategies were, and we pointed this out to the peripatetic manager for attention.

In discussions staff were knowledgeable about each person and were able to describe how they responded to people's needs. We saw staff adapted their approach to each person to meet their differing levels of dementia care and communication needs. For example, speaking slowly and clearly and giving people time to make their own choices.

The staff used monitoring records about pain and depression to check the well-being of people whose dementia meant they were unable to express how they felt. However there were currently no one-page profiles or hospital passport records with immediate details of a person's needs and abilities, such as communication skills. These would be useful if a person living with dementia had to transfer to another service such as hospital.

People's dependency levels were assessed each month and their individual care plans were reviewed on a monthly basis, or more often if people's needs were changing. The community nurse told us that staff at the home were receptive to advice and ideas about changes in people's health care needs, but felt that there were few activities for people although staff "seem to do their best".

The home had an activities co-ordinator who arranged for group activities such as reminiscence sessions and games, and individual activities such as pamper sessions. Some people were provided with individually designed therapeutic activities, such as building blocks for a retired engineer to construct. One person had an empathy doll which supported their well-being and helped to maintain their independent living skills. There were books and rummage boxes for people to use if they wished. One person described how she liked to fold napkins for the dining room. She enjoyed being helpful and felt she was contributing to the running of the home in this way.

Relatives felt the activity co-ordinator tried to encourage people to take part in activities. One relative commented, "They do try to get her involved and paint her nails, but they could do with more engagement for people who are still able to take part."

Although people's daily care needs were being met, there was no additional time for staff to engage people in therapeutic interventions and more activities designed for people with advanced dementia needs. One member of staff commented that the care "sometimes felt mechanistic, with not enough time to sit and talk with the residents". We told the peripatetic manager and regional manager about this. They agreed and confirmed that staffing on the first floor was to be increased by an extra member of care staff to improve the opportunities for therapeutic support for people.

Relatives told us they felt able to approach the staff or the peripatetic manager if they wanted to discuss anything, including any complaints. They said they were confident that these would be dealt with. There was information about complaints in the service user guide, which was an information pack given to people or their relatives when they moved into the home. There were also posters in the reception area about how to make comments, complaints or compliments.

There had been one complaint recorded in the past year. The person who made the complaint said they felt lessons had been learnt from it, and that the service had improved. The peripatetic manager told us that any complaints were now recorded on the provider's datix (management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Requires Improvement

Is the service well-led?

Our findings

People and relatives said there had been recent improvements in the management of the service. This followed recent concerns at the home, particularly in relation to use of agency staff who were not familiar with people's needs or the operations of the home. One relative told us, "It's definitely moving in the right direction." A community nurse told us, "It seems to be getting back on track. There is better leadership, especially clinically."

In October 2014 a joint monitoring visit by the Clinical Commissioning Group (CCG) and the local authority found a number of shortfalls at this service. Since then an experienced peripatetic manager had been managing the home and had started to address the identified shortfalls.

At the time of this inspection there was no registered manager in post at this home. This was because the previous registered manager had recently left to take up employment with another organisation. The provider had recruited another manager but that person had not taken up the post. The provider was again actively recruiting a new manager. In the meantime the peripatetic manager was managing the home until a suitable appointment could be made. Relatives felt the home was well managed at this time and described the peripatetic manager as "helpful" and "supportive".

People who could express a view and their relatives felt they now had the chance to contribute their comments and suggestions about the running of the service. A relative told us, "There have been a few meetings recently and we've been invited to make any comments to the manager." They told us the peripatetic manager was keen to involve people and in planning and shaping the service. For instance, a relative had been involved in a recent interview panel for new staff.

Recently there had been Resident/Relatives' meetings with the peripatetic manager and activities organiser to discuss suggestions for improvements to the service. A member of the inspection team joined a Resident/Relatives meeting on the first day of this inspection. This was a very proactive group. The discussion included the welcome reduction in the reliance on agency staff, building up bank staff, the level of nursing cover on the first floor and the requirement for additional staff. Also discussed were furniture, decoration, upgrade to the bathrooms, improved flooring, successful reduction in odour levels, an enhanced way of planning the menu to involve people in a wider choice of food, more trips in the future, and the use of TV and music in the home. The meeting was well attended by relatives and they told us they felt their views were listened to.

A new initiative introduced by the peripatetic manager was the appointment of 'link' representatives, who were a relative and a friend of people who lived at the home. The 'link' representatives were going to be involved in monitoring the experiences of people who used the service, checking on continuity of care and identifying any praiseworthy practices or any concerns during their visits.

People, relatives and other visitors told us the ethos in the home was good and the atmosphere welcoming. Staff commented that they "look forward to coming to work" and "feel supported in their job". The peripatetic manager was well respected by staff and they felt fully supported by her. All were happy in their work and said that, overall, the company was a good one to work for and they enjoyed their work. We saw there was good teamwork amongst the staff, and several staff took on extra roles to help cover gaps in the staff rotas. The responsibilities of nursing staff were being re-established with designated roles, such as infection control lead and end of life leads. However some updates in relation to current best practice or initiatives relating to dementia care would be a benefit. For example, the home had a dementia champion but not all staff were aware of this so the potentially positive impact of this role was reduced.

Staff meetings were used to support staff with expected standards. We saw minutes of the staff meeting that had been held in October 2014 following the CCG and local authority visit. The meeting discussed the findings of the joint report and the improvements that were needed. In this way, staff were kept informed of issues and were involved in supporting changes and improvements to the service.

The provider had a quality assurance programme which included monthly visits by the regional manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. We saw the regional manager checked that any actions had been completed at the next visit.

The provider had systems in place to analyse incident and accident reports in the home so it could make sure any

Requires Improvement

Is the service well-led?

risks or trends were identified and managed. There were also regular in-house audits, for example of health and safety and the medicines system. A schedule of audits of medicines records had recently been introduced to monitor standards relating to the administration of medicines. It was too early in the audit cycle to comment on their effectiveness at the time of the inspection.

The provider also used an annual customer satisfaction survey to gain people's views of Regents View. The last results from May 2014 showed that people felt the food and standard of care were good, but that bathrooms and toilets needed refurbishment. We saw minutes from a relatives/ residents' meeting in August 2014 where the previous manager had discussed the anticipated refurbishment of bathrooms. However during this inspection it was evident that there were no demonstrable plans in place for this work to take place. In this way, the provider had still not addressed the shortfalls in the standard of the bathrooms at this home.

This section is primarily information for the provider

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15(1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the risks associated with control of infection because provider did not ensure that the premises were a clean and hygienic environment for the people who lived there. Regulation 12(1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard. Regulation 23(1)(a)