Veecare Ltd

Tralee Rest Home

Inspection report

38-40 Tankerton Road
Whitstable
Kent
CT5 2AB

Tel: 01227276307
Website: www.carehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 4 and 5 December 2018. The inspection was unannounced.

Tralee Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Tralee Rest Home is registered to provide accommodation and personal care for 36 older people and people who live with dementia. There were 23 people living in the service at the time of our inspection. The service is a large detached and extended house situated in a residential area just outside Whitstable.

Our last full inspection of this service took place in October 2017. Following this inspection, the key areas of Effective and Caring were rated as Good, while the areas of Safe, Responsive and Well Led were rated as Requires Improvement, together with the overall rating of the service. This was because more action needed to be taken about people who experienced falls; including more detailed audit processes. Care plans about epilepsy had been produced but needed more detail to make them truly effective. Other care plans were written in a person-centred way but had not always been updated when people's needs changed. Medicines were generally managed safely but administration practices needed to be more consistent and recording of refused doses improved. Not all concerns raised by complainants had been logged and responded to before they became formal complaints. Audits of care plan reviews had failed to identify that details were incomplete, not always accurate or up to date. In addition, they did not consider impact on individuals in terms of reducing risk and ensuring all had been done provide support for people.

We told the registered provider to send us each month an update about the running of the service, what improvements they had made and intended to make to address our concerns and bring about improvement. The registered provider complied with this requirement.

At this inspection some improvement had been made. Incidents and accidents were all reviewed and the results used to inform any changes needed to reduce the risk of recurrence. Falls were well managed, associated risk assessments were updated and people had received support needed to reduce the risk of repeated falls. Care planning had improved and were mostly reflective of people's current needs, however reviews of care plans had missed the opportunity to check for completeness and develop best practice procedures. Medicines were generally managed safely, although a piece of equipment used to test blood sugar levels had not been periodically calibrated and the service did not hold a stock of test fluid to allow this to be done. Complaints had been logged and responded to in line with the policy in place. Auditing and oversight had improved; however they had not been used to their expected potential as tools to assess the quality and safety of the service provided or develop best practice and continuous improvement.

As the result of this inspection, the service was rated as Requires Improvement. This is the second consecutive time Tralee Rest Home has been rated as Requires Improvement.

People were protected from harm by staff who were trained to recognise signs of abuse. However, recruitment processes did not ensure risk assessments were completed before the employment of staff for whom cautions, or convictions were recorded. Additionally, a policy was not in place to support such a process.

There were enough staff to meet people's day to day care needs. However, people's preferences about when they went to bed were not fully considered in the deployment of staff and may impact on or influence people's choices.

Pre-assessments for people moving to the service were comprehensive. Staff were able to tell us confidently about the care and support people needed for specific conditions; potential risks to people's health and welfare were identified and there was guidance for staff to follow. However, occasionally guidance would have benefitted from further detail to ensure quality of delivery and clearly determine a level for consistency.

Appropriate arrangements were in place to assess people's needs and choices so that care achieved effective outcomes. This included providing people with the reassurance they needed if they became distressed. Care staff knew how to provide practical assistance for people in the right way and had received training and guidance. People were helped to eat and drink enough to maintain a balanced diet. Suitable provision had been made to help people receive coordinated care when they moved between different services. People had been supported to access all the healthcare services they needed. Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

People had been supported by relatives and representatives to express their views about things that were important to them. This included them having access to lay advocates if necessary. Confidential information was kept private.

People received practical assistance to complete everyday tasks and suitable arrangements had been made to promote equality and diversity. Suitable steps had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

The building was adapted to meet people's needs. Staff completed checks on the environment and equipment, these helped to ensure people were safe. Good standards of hygiene were achieved to prevent and control the risk of infection.

The registered manager had promoted an open and inclusive culture in the service. They were actively working in partnership with other agencies to support the development of joined-up care.

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 consistently safe.

People received their medicines safely from staff who were trained to do so, however, blood sugar level monitoring equipment was not checked when it should have been.

There were enough staff available to meet the needs of people, however, night staff arrangements required further consideration to ensure staff availability did not unduly influence people's decisions about when they went to bed.

Staff were recruited safely, however, processes were lacking in the event that statutory checks revealed cautions or convictions.

People were protected from the risk of abuse.

Risks to people and the environment were assessed, and staff took action to reduce those risks identified.

People were protected by the prevention and control of infection.

The registered manager took steps to ensure lessons were learned when things went wrong.□□

Is the service effective?

Good

The service was effective.

People's needs were assessed with them and their relatives when necessary.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People were supported to make their own decisions.

Staff were supported and had the skills they required to provide the care people needed.

People were supported to eat and drink enough to help keep them as healthy as possible.

People were supported to remain healthy.

The building was designed to support people to be as independent as possible.□□□□

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

People were supported to express their views about the support they received.

People had their privacy and dignity respected and promoted. □□

Is the service responsive?

Good

The service was responsive.

People had planned their care with staff and received their care how they preferred, however, some care plans were contradictory in places.

People participated in a variety of activities.

Any concerns people had been resolved to their satisfaction.

People were supported in the way they preferred at the end of their life.□□□□

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Checks completed on the quality of the service had improved but required further development and embedding to ensure they drove forward improvement and sustained the changes made.

People, their relatives and staff shared their views and experiences of the service and these were acted on.

Staff shared the provider's vision of good quality care.

Staff were motivated and led by the registered manager. They had clear roles and responsibilities and were held accountable for their actions.

The managers worked with other agencies to ensure people's needs were met.□□□	

Tralee Rest 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 4 and 5 December 2018 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 11 people who lived at Tralee Rest Home, we observed some people's care, the lunchtime meal, some medicine administration and activities. We spoke with two people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with one senior carer, two care assistants, the kitchen and housekeeping staff as well as the registered manager.

We observed care provided in communal areas and looked at the care records for seven people. We also looked at records that related to how the service was managed including staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems, we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events, their interaction with each other and with staff.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe, one person commented, "I feel safe because I never feel alone, when I am in my room staff look in on me. I find that reassuring." Another person told us, "I feel safe and have no worries or concerns."

At our last inspection, falls were not well managed. This was because strategies intended to reduce their occurrence were not effective and referrals were not always made to healthcare professionals who may have been able to provide help and advice.

At this inspection required improvement had been made. Incidents and accidents, including falls, were well managed. All incidents and accidents were recorded and analysed to look for patterns and trends and action was taken to reduce the risk of accidents occurring again. People's falls risk assessments were reviewed and updated after a fall and action had been agreed with them to reduce the risk of them falling again. Some people living with dementia used alert mats to let staff know when they were mobile in their bedroom. This reduced the risk of them falling as staff were alerted to support them. Referrals were made to healthcare professionals when needed and any advice followed, for example consideration of bed rails, reducing the height of profiling beds, rearranging of bedroom layout and furniture and the use of crash mats next to a bed if needed. In addition, staff tested to see if people who had fallen had urinary tract infections (UTI) as symptoms include confusion, agitation, and a loss of balance that can lead to falls. Occurrences of falls were low and had reduced in the three months before our inspection. Analysis of incidents and accidents ensured any trends were identified and addressed. For example, where a UTI was present referrals were made to the GP for medicine to treat it and staff made records of what people had drunk to ensure dehydration was not a contributing factor.

At our last inspection we identified disposal of medicines as an area needing improvement, this was because there were not full records of a medicine that had been disposed of.

At this inspection we found improvement had been made. Appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines. People received their medicines when they needed them, staff had received appropriate training and competency supervision. There were clear protocols in place to make sure people received the right amount of medicines safely and on time. Staff were aware of people's conditions and the medicines they received. People's medicine administration records (MARs) included a photograph of the person to help staff administer the right medicine to the right person. All medicines were stored securely in line with current guidance. Effective systems were in operation to order and receive medicines, including new and short-term medicines such as antibiotics. Clear records were kept of all medicine that had been given, they were up to date and had no gaps; all medicines given had been signed for. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN). This included a pain assessment chart, which staff used to help people tell them if they were in pain and how much. Staff gave and recorded the correct dose of pain relief. Regular medicine audits were carried out by the registered manager or key staff. This helped to ensure people received all their medicines safely. Application of medicated creams were recorded separately and completed consistently. However,

the blood sugar monitoring equipment, used by the service for people with diabetes, should be periodically calibrated in line with manufactures' instructions. This was to ensure it produced accurate readings. Discussions with the registered manager and staff found no calibrations checks took place. This is an area identified as needing improvement.

An established recruitment process was in place. Evidence of conduct in previous employment, references and proof of identity were obtained and staff were not allowed to start work until these checks were completed. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, following a review of policies and procedures with the registered manager, we found there was no policy in place to address risks associated where previous cautions or convictions were recorded. This meant there was no process, if needed, to mitigate any risk associated with employing a person where a positive disclosure had been received. A review of staff files found one person had previously been employed at the service without any risk assessment despite a recoded conviction. While the person no longer worked at Tralee, this confirmed a deficiency in recruitment procedures and is an area identified as needing improvement.

We observed staffing levels were sufficient and staff worked at a calm pace to support people to get up and ready for the day. Personal care was completed when and in the way people wanted. Staff spent time with people throughout the inspection. People enjoyed this and told us staffing levels were appropriate. Staff felt they were not rushed and there was enough time to give people the support they wanted. Some people told us they could have a shower or bath each day if they wanted to and were happy with this. However, another person told us they could not shower as often as they would like to. We discussed this with the registered manager, they spoke with the person and were able to resolve this issue with them. The registered manager routinely reviewed people's needs against the deployment of staff and was confident that staffing was flexible enough to respond to changing needs. Agency staff were occasionally used, they received a familiarisation induction to the service and the tasks they were required to do.

However, the dependency assessment provided to us by the registered manager showed there were six people who required the support of two staff to move them. While we found it did not present a problem for people currently living at the service, since the night staff consisted of two staff who started their shift at 8pm, this effectively meant people needing the support of two staff needed to be in bed before 8pm. This was because after 8pm, with only two staff present, they could not leave other people unattended. Night staffing levels could therefore influence people's decisions about when they wanted to go to bed. We discussed this with the registered manager and while they pointed out an on-call system was operational, they agreed to review night staffing arrangements, for example, by overlapping shift times for some staff to provide a greater number of staff on duty later at the service. Nevertheless, this is an area identified as needing improvement.

Risks to people had been assessed and action was taken to mitigate them and support people to remain independent. People were supported to manage the risk of developing pressure ulcers; their condition was assessed continually using nationally recognised risk assessment tools. For example, when at risk of skin breakdown, people were supported to change their position regularly, prescribed creams were applied as directed and staff used pressure relieving equipment safely. Detailed guidance was provided to staff about how to use this equipment, how to ensure the pressure settings were correct and the equipment was working properly. The equipment we checked was being used correctly and regular reviews of people's condition ensured potential skin damage managed safely.

People were protected from the risk of choking. When staff identified that people may be at risk they

referred people to a speech and language therapist. Guidance received about how to prepare meals, such as to mash foods or thicken drinks was used to plan people's care and followed by staff. Staff ensured people vulnerable to choking were supervised while they ate or drank, and staff were regularly competency checked to ensure they knew what to do in the event of a choking incident.

People were moved safely. Guidance was provided to staff about the equipment and techniques they should use to move people. We observed several transfers of people; staff used the right equipment correctly, they were confident in how they used it and reassured people throughout the moving process. People were relaxed and trusted staff to support them to move safely, one person told us, "There are always two staff to help me move from my wheel chair to the lounge chair. They are gentle and tell me how they are going to move me, it doesn't worry me at all, in fact I'd be more worried if I thought I had to get out of my wheel chair on my own."

Staff followed positive behaviour support plans to help people manage any behaviours that challenged. Plans included any potential triggers and how to respond to prevent people becoming upset or anxious. We saw staff anticipate when the triggers may occur, such as one person getting too close to another person. Staff supported people to avoid triggers, including guiding people to other areas of the room. This helped people to remain calm and relaxed.

People were protected from the risk of abuse and discrimination. Policies were in operation to safeguard people from abuse and available to staff. Staff told us about different types of abuse and were comfortable to report any concerns they had to the registered manager or provider. Staff were confident any concerns they raised would be addressed quickly. The registered manager discussed any concerns with the local authority safeguarding team and acted on their advice to keep people safe. Staff knew how to whistle blow outside of the service if they needed to.

Checks took place to help ensure the safety of people, staff and visitors. Portable electrical appliances and firefighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Testing and monitoring of water temperatures was up to date and did not identify any concerns. Plans were in place and understood by staff about how to support people in an emergency. These included supporting people to move to other parts of the building if needed. Staff were trained and confident to use the equipment to evacuate people and where to locate it. Fire exits were clear and unobstructed. Staff had completed fire training and took part in regular fire drills. Regular checks were completed on the building and equipment to make sure it was safe.

The service was clean and people were protected from the risk of the spread of infection. Staff had completed infection control and food hygiene training. The registered manager made sure protective equipment, such as aprons and gloves were easily available to staff and we saw staff using them throughout our inspection.

Good

Is the service effective?

Our findings

People told us the service was effective in meeting their needs and staff were skilled in carrying out their roles. One person told us, "The staff are well trained, they make sure they tell me what they are doing when they help me." People were complimentary about the variety and quality of food, one person told us, "There is a good choice of food, it's appetising."

People's care and support was delivered in line with current legislation. Each person had their own individual care plan which showed how the person wanted to be supported. Records included information about the person's physical and mental health needs. Care planning considered any additional support that might be required to ensure people did not suffer from discrimination, such as needs around cultural or religious beliefs, and other protected characteristics under the Equality Act 2010. The Act makes it against the law to discriminate against a person because of a protected characteristic, which includes their age, disability, sexual orientation or religion.

Meal times were well organised and people received the support and supervision they needed. Organisation within the kitchen ensured people received the correct meal choices and that they were prepared in a way that was safe for them to eat. For example, some meals were softened and others were fortified to suit individual needs. Information was to hand for staff about what to do if someone was choking and discussion with staff found they were confident and well versed in what to do in such a situation.

People were supported to eat and drink enough to maintain a balanced diet. People told us they were involved in planning menus and provided feedback to the cook. Menus looked nutritious and well balanced. Meals were mostly eaten together in the dining area, although some people chose to eat in different parts of the home. Picture card menus with a bold print description were used to help some people choose what they wanted to eat. Where needed, plate guards were used to help people eat independently and staff prompted other people to eat with hand on hand support or verbally orientating people to what they were doing.

Where concerns were identified around how much people ate or drank, records were kept. This enabled staff to track how much people ate and formed a starting point for dieticians to decide if fortified or food supplements were required. Fluid charts guided staff about how much people should drink in a 24 hour period, records were up to date and staff were aware of potential signs of dehydration and what to do. People were weighed regularly and in the event of weight loss, appropriate referrals were made and support sought. Where fortified meals were recommended, or supplementary drinks prescribed, records, staff and some people confirmed they were given. Throughout the inspection people were offered drinks and snacks. One person told us, "The food is most enjoyable." A visitor told us they sometimes ate at the service, they thought staff were attentive to people during meal times and had always enjoyed the meals they had eaten.

Staff had the skills and experience to deliver effective care and support. Staff told us they had an induction when they started working at the service, this involved time with a manager, reading people's care records, policies and procedures and getting to know the service. They also spent several shifts shadowing

experienced colleagues to get to know people and their individual routines. New staff received a comprehensive programme of training before they started working with people. New staff were completing the Care Certificate; a set of standards that social care workers follow in their daily working lives. Staff were supported through their induction, monitored and assessed to check that they had the right skills and knowledge to be able to care for, support and meet people's needs effectively. Staff received support during formal one to one meetings with the registered manager; some meetings were planned in advance, while others were in response to situations arising. Staff discussed issues that had happened in the service and reflected on their practice. A schedule of supervision and appraisal ensured their frequency reflected the service's policy.

There was an ongoing schedule of training. Staff had completed a mixture of e learning and face to face training in a range of subjects which enabled them to perform their roles safely and to provide the right care and support to meet people's needs. Training in all mandatory subjects was up to date for most staff. Our observations found that staff were both competent and confident in delivering personalised care. Staff had also undertaken extra training in subjects such as challenging behaviour, dementia awareness, diabetes, catheter, stoma and end of life care. Competency checks were completed after training sessions to check staff knowledge and understanding. All staff told us the training was of a good standard.

Staff worked well with each other and other organisations to deliver effective care and support. We saw positive but discrete communication between staff members when discussing people's needs. At the end of each shift, senior staff carried out a handover which made sure incoming staff were aware of any issues or concerns. Staff knew to make referrals to other health and social care professionals when required. For example, one person had recently been referred to a specialist nurse when they developed a new health condition. Staff kept accurate details of people's health needs and preferences, which could be given to health staff if the person needed to attend an appointment at hospital. This included detail of the person's medicines and how they prefer to take them.

Regular staff gatherings took place for 10 minutes daily. These were led by the registered manager and attended by all staff; they provided an opportunity for collective understanding of common issues and an opportunity for the registered manager to assess staff awareness of processes and the location of equipment. For example, how to place a person into the recovery position, how to recognise and what to do if a person was choking, where the evacuation chairs were located and how personal protective equipment (gloves and aprons) should be worn then removed and disposed of to minimise the possibility of contamination.

People were supported to have timely access to healthcare services and staff arranged for people to have regular reviews of their health and medicines; people's health was monitored to help maintain their well-being. Physiotherapists, speech and language therapists, occupational health practitioners, opticians, chiropodists and GPs all visited the service to assess people and contribute to their care and support on a regular basis. Where people had particular healthcare needs; such as diabetes, skin integrity concerns or choking risks, care plans had been put in place. These informed staff of the actions they should take to support people.

People's needs were met by the design and decoration of the premises. Tralee provides accommodation and support for older people, many of them living with dementia. The registered manager had due regard to guidance of best practice for a dementia care setting. For example, there were handrails in corridors to aid mobility. Signage to toilets and lounge areas were easily visible and in written and pictorial forms and door frames to toilets were painted a different colour to other rooms which helped to aid people's awareness of their surroundings. People's bedrooms were personalised with their own possessions, photographs and

pictures. They were decorated as the person wished and were well maintained. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use.

At this inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). Applications had been made for deprivation of liberty safeguards (DoLS) authorisations for people who needed them, seven authorisations were granted with the remainder being processed. These authorisations were applied for when it was necessary to restrict people for their own safety. The service was responsible for making applications and the relevant supervisory body (local authority) considered each application, issuing authorisations as needed. This ensured any restrictions on people's liberty were warranted and the least restrictive as possible. A review of granted authorisations found conditions attached to an authorisation were actively observed. Where authorisations had been made, the registered manager had made sure people could see their relevant person's representative (RPR). The role of the RPR is to maintain contact with the relevant person, and to represent and provide support, that is independent of the commissioners and providers of the services they are receiving, in all matters relating to the deprivation of liberty safeguards. An RPR is appointed by the local authority.

Records showed people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The management and staff had knowledge of and had completed training in the MCA and DoLS. Staff showed good knowledge and understanding of the MCA. We observed staff offering people choices and they told us about people who needed more help to make their own decisions. Most people were able to make day to day choices about what they wanted to do, eat and wear. Staff asked people for their consent before placing an apron over their clothes, to protect them when eating. All staff knocked on bedroom doors and asked for consent before entering their room. If a person was unable to make a more complex decision, then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

Good

Is the service caring?

Our findings

People told us they felt well supported by the staff, describing them as warm, friendly and accommodating of their requests and support needs.

Staff spoke to people with courtesy and kindness and it was clear that relationships of trust had been built. For example, one person needed reassurance with their anxiety at different points during the inspection, because they wanted to return home. Staff responded to them with compassion and patience on each occasion; they had created a bus stop with a bench inside the service and sat with the person, making time to comfort and distract them from their anxieties with a cup of tea and a chat. The person reminisced and spoke with staff about their former work and how they would have journeyed home. The engagement of staff at that point in the person's recollections gave validation to their earlier life, while staff gently orientated the person to their life at Tralee. The person was satisfied to sit and chat, they relaxed and when settled, happily re-joined other people in the main lounge. We saw this approach was beneficial to a number of people at the service, with staff adapting their approach to ensure relevant context and conversation with the person they were supporting.

There was a clear person centred culture at the service and a commitment to supporting people to express their views, feelings and maintain their independence. Staff knew about people's background, their preferences, likes and dislikes and supported people in a way that they preferred. One visitor told us, "I am very satisfied with the support my relative receives. Staff go the extra mile, for example they use the same Jersey milk for her coffee as she used to have at home." Another person, unprompted, told us, "I am very happy here."

People were supported to maintain important relationships. Relatives told us there were no restrictions on the times they could visit, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us how staff contacted them if they had any concerns about their family members.

People received discreet assistance, which allowed them to stay independent with some tasks. For example, people told us about the support they received with personal care and how staff only did what they wanted them to rather than trying to take over. One person told us, "The staff are always very kind to me."

Staff were attentive. They observed and listened to what people were saying. They picked up on communication cues such as use of arms and hands to communicate yes or no and facial expressions and body posture which may indicate discomfort. Staff knew people well and were easily able to hold a conversation with them. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner and, where possible, ensured they were involved in conversations. All staff interacted well with people, including housekeeping, kitchen and maintenance staff, who knew people by name and stopped to chat and share humour with them.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their needs. People were moving freely around the home between their own private space and communal areas. Staff knocked on people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discreet support with their personal care.

People's care plans told us how their religious needs would be met if they indicated they wished to practice. People were supported to be involved in decisions about their care. When people could make more complex decisions the care plan was agreed with them. Staff were guided by their choices and respected their decisions. Some people signed their care plans to confirm they agreed with them.

People's information was kept securely and well organised. Staff were aware of the need for confidentiality and meetings were held in private.

Good

Is the service responsive?

Our findings

People were supported to have their needs met by a staff team who knew them well. One person told us "The staff are excellent in how they help me," another person commented, "I like to try to do as much myself as I can, but staff always make sure I have my call bell, so I can call for help if I need to. On the times that I've used it, they come to check on me quite quickly; I don't feel as though I have to wait too long at all." A visitor told us, "I am confident in the care and support provided."

At our last inspection, the management of complaints was not consistently effective because not all matters brought to the attention of the registered manager and needing remedial action had been properly recorded. At this inspection, concerns and complaints had been documented and responded to appropriately. The provider had a complaints process in place, which advised people how complaints would be handled and how to escalate their complaint if they if they were not satisfied with how it was dealt with. The complaints process was available in the entrance of the service. Complaints we reviewed had been resolved to the complainant's satisfaction and steps put into place to try to minimise the risk of events reoccurring. The registered manager recorded all matters brought to their attention, together with how these had been responded to. People and visitors we spoke with were confident any complaint or concern raised would be properly looked into and replied to. They were complimentary of the openness of staff and the registered manager because of their resolve to address any concern raised fully and at the earliest opportunity.
Each person had a care plan covering each aspect of their care and support, including details about their choices and preferences. Senior staff and the registered manager regularly reviewed care plans to ensure they were up to date and reflective of people's changing needs. Staff told us confidently and in detail about how people with certain conditions needed to be supported, for example, when changing a stoma bag, carrying out catheter care, supporting people with different types of diabetes or epilepsy and safeguarding against skin damage. Most guidance about specific tasks or conditions was very detailed, however, other guidance would have benefitted from further development. For example, one person wore a protective inflatable boot to protect a damaged area of skin on their foot. While care was delivered in line with specialist advice and we saw protective equipment was used, guidance about the support required only existed in District Nurse notes and had not been transferred into the person's care plan; although it was reflected in their risk assessments and staff described the care and support needed. We discussed this inconsistency with the registered manager. This had been an oversight and the care plan was immediately amended. Otherwise, care plans provided the detail of care needed and staff were proficient in its delivery.

Within care plans there were life histories, guidance on communication and personal risk assessments. In addition, there was guidance describing how the staff should support the person with various day to day needs, including what they could and could not do for themselves, what they needed help with and how to support them. Care plans contained information and guidance on people's likes and dislikes around food, drinks and activities. For example, they documented what time people liked to get up and go to bed and what toiletries a person liked, to help staff be sure they supported people in the way they preferred. Easy to use pain assessment charts were in place, designed to support people and staff in identifying pain when people could not verbally express their pain.

When people needed support with moving and handling there was information about the type of sling and hoist they needed and how staff should support them effectively. Health plans detailed people's health care needs and involvement of any health care professionals. Each person had a healthcare plan, which gave healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were regularly reviewed and reflected the care and support given to people during the inspection.

There were a range of activities available to support people to remain both physically and mentally active. These were organised with people's input by the service's activity coordinator. People enjoyed keep fit exercises, music for health, quizzes and visiting musicians. Staff, visitors and a local sea cadet group sent people postcards from their travels which were used as topics of discussion and to prompt people's memories. A Christmas meal was planned to which people and visitors were invited. Local school children visited the service and plans were in place for people to visit children at a local school if they wanted to. The service involved itself with the local community, undertaking a scarecrow build and planned to borrow costumes for a local theatre that people could use for a photo shoot. The service worked with Age UK so people received companionship visits and could go shopping. Staff and their children hosted a Tralee Has Talent show, which was well received by all those who attended. Other national events were celebrated, such as the Royal wedding, the Queen's birthday, Wimbledon and other sports events. During the inspection and in the lead up to Christmas, people enjoyed a Christmas film each day that they had chosen and were busy making decorations for around the service. While most people enjoyed group activities, staff were careful to give one to one time for people who preferred not to join in. People smiled, laughed and sang during the activities. A planner in the lounge let people know which activities were taking place and when.

Although nobody was receiving end of life care, staff were aware of the importance of supporting people at the end of their lives. People were asked about their end of life wishes and these were recorded. Some people had declined to discuss their wishes, and this was respected, but where expressed, staff were aware of people's cultural and spiritual needs regarding their end of life wishes. Staff liaised with the GP and other health professionals to ensure people's needs were met and made sure that pain relief medicine was available when people needed it.

Staff understood the importance of promoting equality and diversity. People could meet their spiritual needs by attending a weekly non-denomination religious ceremony if they wished to do so. A visiting minister provided holy communion if people wished to receive it. People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background, life choices and sexual orientation.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. They provided information in large print written form such as menus and meeting minutes, together with an audio version of the service's statement of purpose and complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the service had not been well-led. We found a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, audits and checks continued to be carried out each month by the registered manager, the provider and staff with key responsibilities together with an external consultant. Some audits focussed on particular aspects, such as medicines and skin integrity, while other audits emulated the key domain areas and lines of enquiry used by ourselves, the CQC.

While again there was positive improvement in many areas of the service, not all checks had reached their expected potential as tools to assess the quality and safety of the service and develop methods of best practice and continuous improvement. For example, reviews of care plans had missed the opportunity to check for completeness and develop best practice procedures, such as when specialist advice and support was received from a healthcare professional. Audits of procedures, such as recruitment, had failed to identify missing steps when convictions were recorded and, additionally, had failed to identify gaps within policies to deal with this. Medication audits had failed to identify that equipment used to check blood sugar levels was not calibrated, or that there was no stock of calibration fluid held within the service. While staffing appeared adequate, night staffing arrangements were not fully considered to ensure staff availability did not influence people's decisions about what time they went to bed. Yet the checks in place and those introduced following our last inspection had, to some extent, resulted in improvement.

We therefore considered that further time and development was required to ensure the measures in place were wholly effective in sustaining progress and driving forward the continuous improvement of the service. Particularly given that the service was operating at approximately two thirds capacity and when the occupancy of the service increases, there will be increased demands on staff and management of the service.

The managers had formed positive working relationships with healthcare professionals to benefit people living at the service. Staff had formed good relationships with district nurses, the GP and other professional visitors to the service. The managers had a good working relationship with commissioners and had booked for staff to attend training with the CCG.

People, relatives and staff told us of improvements in the culture of the service since the current registered manager had started. Staff agreed leadership had improved greatly and felt all staff worked better as a team and communicated better, which had had a positive impact on the people living at the service.

The registered manager told us they were well supported by the provider. However, we felt the provider could develop closer working between sister services and this may serve to improve consistency and best practice.

Regular resident and relative's meetings were scheduled to give people and their relatives the opportunity

to discuss the service. During the meeting people were given updates on staff recruitment and changes as well as what was working well in the service, and what staff were working on improving.

The provider had sought feedback from relatives in the form of a questionnaire. The results of the questionnaires had been collated and were positive. Feedback from people living at the service had been sent out and had been made available in a format accessible to everyone. Any suggestions people made were implemented, which largely related to food choices and ideas for activities. The provider had also created questionnaires to be sent to healthcare professionals for their feedback.

Staff meetings were scheduled regularly and included discussion of any accidents and incidents over that period of time, as well as a review and update of the service progress. The registered manager took this time to refresh staff knowledge on key topics and use the meeting as a learning opportunity.

The registered manager told us they kept their skills up to date by reviewing good practice guidance from NICE and CQC, as well as ensuring they kept their training up to date. The registered manager belonged to a registered managers forum and used this as a tool to develop good practice.

The managers had notified the Care Quality Commission of important events as required. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the managers had conspicuously displayed their rating in the service and the provider had displayed the service's rating on their website. The managers were also aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support.