Coxbench Hall Limited

Coxbench Hall

Inspection report

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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

This unannounced inspection took place on 14 and 19 September 2016. The service was last inspected on 30 September and 1 October 2015 when we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the provider not having effective systems to ensure compliance. We asked the provider to send us an action plan to demonstrate how they would make improvements to meet the regulations. The provider sent us their action plan, and on this inspection, we found improvements had been made. However, we identified several areas where improvements needed to be made to the quality of care on this inspection.

Coxbench Hall is registered to provide accommodation and personal care for up to 35 people. At the time of our inspection, 35 people were living there. Coxbench Hall is a period building that has been adapted to the needs of people in residential care. The building has three floors, accessible by stairs and a lift. The gardens are spacious and well maintained, with several outside sheltered seating areas for people.

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

We found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not consistently managed in a safe way and in accordance with current guidance and legislation. We saw on the second day of the inspection visit that action had been taken to address this.

People's care needs were assessed and recorded and risks identified. However, risk assessments and care plans did not consistently identify steps staff should take to reduce the risk of avoidable harm. We spoke with the provider about this, and saw that improvements had been made on the second day of the inspection visit.

There were systems to monitor and review all aspects of the service, and these were undertaken regularly. However, the systems did not always identify where areas of care needed to be improved. This meant the provider was not always able to identify areas for improvement, and to make changes to improve the quality of the service for people. We saw on the second day of the inspection visit that action had been taken to improve the systems to monitor and review the quality of care.

People had their care reviewed on a regular basis, and they and their relatives were involved in this. There were enough staff to ensure that people's needs were met in a timely manner.

People felt the care provided kept them safe, and relatives also felt this was the case. Staff understood how

to keep people safe from the risk of potential abuse.

People and relatives spoke positively about staff, saying they were cared for by staff who treated them with kindness, dignity and respect. They were encouraged to continue with hobbies and interests, and to maintain relationships that were important to them. People were also cared for by staff who were knowledgeable, skilled and trained to provide personal care to the standards set by the provider.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), including how to support people to make their own decisions. The provider was working in accordance with the MCA, and people had their rights upheld in this respect.

People and their relatives were positive about the quality and choice of food and drinks. We also found that people were supported to maintain their health and to access healthcare services when required.

The provider had a clear complaints policy, and people and relatives felt able to make a complaint or raise concerns. The provider investigated complaints according to their policy, and created opportunities for people to provide regular feedback about the service, which was acted on.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not always managed safely. Risk assessments did not consistently identify measures to minimise the risk of avoidable harm. People felt safe, and were supported by enough staff to meet their needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who were skilled and knowledgeable to meet their care needs. Staff understood the principles of the Mental Capacity Act 2005 (MCA), including how to support people to make their own decisions. People had a varied diet that gave them sufficient to eat and drink, and they were supported to access health services when needed.

Is the service caring?

Good

The service was caring.

People and relatives consistently praised the quality of care. Staff took time to get to know people to enable them to provide person-centred care. People were treated with dignity and respect, and encouraged to retain their independence.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in their care planning. There was a range of activities, and people were supported to continue to enjoy hobbies and interests. The provider actively sought the views of people, relatives and other professionals, and used feedback to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor and assess the quality of care did

not always identify gaps in medicines management, or omissions in risk assessments and care plans. People, relatives and staff spoke positively about the management of the service, and there was an open and inclusive culture.

Coxbench Hall

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 14 and 19 September 2016 and was unannounced. The inspection visit was conducted by three inspectors on the first day. The second inspection visit was announced and undertaken by one inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with nine people who used the service. We spoke with four relatives who were visiting people living at the service. We spoke with five care staff, one kitchen staff, the deputy manager, the office manager, and the registered manager. We also received the views of six health and social care professionals. We looked at a range of records related to how the service was managed. These included six people's care records, and eight people's medicine administration records, four staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand

the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not managed safely. The provider could not assure themselves that people received medicines as prescribed because their records were not accurate. We looked at eight people's medicine administration records (MAR) and checked the stocks of seven people's medicines. One person had three different medicine doses that could not be accounted for. Another person's medicines needed two staff to sign records to demonstrate they had been received into the service. Staff had not signed the medicine in, and the correct dose of medicine had not been recorded. A third person had 23 extra tablets that could not be accounted for. This meant there was a potential risk that people had not received medicines as prescribed.

A fourth person was being given medicines covertly. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. The person's care plans showed they struggled to swallow tablets and therefore did not like taking medicines. Although the person had one medicine in an easy to swallow form, the rest were tablets. Staff confirmed a GP made the decision to administer covert medicines by crushing the tablets. Staff said advice had been sought from a pharmacist, who confirmed this was an appropriate way of ensuring the person received medicines as prescribed. Staff told us all of the person's medicines were crushed together and this was disguised in a food. There were no records assessing the person's capacity to consent, or evidence of a best interest decision in accordance with the Mental Capacity Act 2005 (MCA). There were no records confirming the GP decision or pharmacy advice that it was safe to crush all the medicines together. The MAR advice for one of the medicines said it should not be crushed. This meant the person was at risk from receiving medicines in a manner which was potentially unsafe, and not in accordance with legislation and best practice guidance.

We spoke with staff and management about this, and they assured us action would be taken. On the second day of the inspection visit, we saw that staff had done an audit of all medicines, and were taking steps to ensure that people would receive medicines as prescribed. The provider was also taking steps to liaise with the GP surgery to ensure the use of covert medicines was safe and in accordance with the MCA.

People were not consistently kept safe from the risk of avoidable harm. Risk assessments were carried out in relation to personal care activities, and were reviewed every month. However, these did not identify what control measures (or actions) staff should take to minimise the likelihood of harm. Risk assessments were not consistently reviewed following accidents or incidents. For example, records showed one person had three falls in July 2016. There was a risk assessment in place in relation to falls, but this did not identify control measures and had not been reviewed after each fall. Another person's care plan for their diagnoses stated they were at risk of falls. There was no risk assessment or care plan in place to ensure staff knew how to minimise the risk of avoidable harm. We spoke with the deputy manager and registered manager about this, and they acknowledged action needed to be taken to ensure risks to people were mitigated. We saw on the second day of the inspection visit that action had been taken to ensure that people were safe from the risk of avoidable harm.

Accidents and incidents were recorded, and the registered manager monitored and reviewed the outcome of any actions needed. For example, we saw people were referred to the falls clinic for specialist support where this was needed.

There were enough staff to keep people safe and meet their needs. People and relatives felt there were enough staff available. One person said, "They [staff] are always around." A relative commented, "There are lots of staff. There is always someone around." Another relative said, "When [my family member] needs anything they are there." Staff told us, and we saw there were enough staff to ensure people's needs were met in a timely manner. Health and social care professional did not raise any concerns about staff numbers or deployment in the service. This meant the provider ensured there were enough staff available to meet people's needs and keep them safe.

People told us they felt safe living at the service. One person said, "Staff are very good; they look after us the best they can." A relative said, "Staff are attentive and are looking to see what help you need." Another relative said, when asked about safe care, "They [staff] do this really well."

People, relatives and staff were supported to speak up and felt concerns would be treated seriously. Staff demonstrated a clear understanding of how to keep people safe from abuse and the risk of avoidable harm, and told us about situations where they had raised concerns appropriately. Staff felt confident to raise concerns about people's care, and knew who to share their concerns with. Staff also knew and felt confident to report concerns to the local authority or the Care Quality Commission (CQC) if they felt this was necessary. Information was displayed in the service for everyone to use if they had concerns about people's safety or the risk of abuse.

The provider undertook pre-employment checks to ensure prospective staff were suitable to care for people. This included checking references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is suitable to work with vulnerable people. All staff had an induction and probationary period to give the provider an opportunity to check they had the skills and values needed for the role.

People were supported to remain safe in the event of an emergency. Staff understood what their role and responsibilities were if there was an emergency or unforeseen event. The provider had up to date personal emergency evacuation plans for everyone who lived at the service. These contained important information about how people needed to be supported in the event of an emergency, for example, fire evacuation. The provider had a contingency plan in place to ensure people continued to receive support in the event of the building becoming unusable, for example, if there was a fire or disruption to utilities.

Good

Is the service effective?

Our findings

People and their relatives felt that staff were knowledgeable and skilled to provide care. One person said, "Staff are absolutely brilliant." Staff were knowledgeable about people's individual needs and how to support them. Staff spoke with us about people's personal care needs, and records confirmed staff understood what care and support people needed to remain safe and well. Staff told us they used notebooks to record key information which was then transferred to people's daily care records, and we saw how this was done. The provider ensured staff had access to relevant information about people's daily health and care needs. For example, senior care staff met at the start of every shift to receive an update from staff who were finishing their shift. We saw and heard essential information being shared between staff about people's hospital appointments, visits from district nurses, and how people were supported to participate in activities. This information was also recorded in people's daily care records. The provider told us they were exploring the purchase of new computer software to support staff to keep more accurate and contemporaneous records. This meant staff had up to date knowledge about people's personal care and other aspects of their health and well-being.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People were assessed in relation to their capacity to make decisions about their care. Where they were able to make their own decisions, their care plans recorded this. For example, one person's care records stated, "I make my own decisions. I understand there can be risks associated with my choices but would like staff to talk to me about these risks so I can make an informed decision." Where people lacked capacity to make certain decisions, the provider followed the principles of the MCA to ensure best interest decisions were made lawfully. However, the recording of capacity assessments did not always clearly identify which decisions were being assessed, or record how a best interest decision had been made. We spoke with the registered manager about this and they assured us they would address this. Staff had good understanding of the principles of the MCA and DoLS, including how to support people to make their own decisions. The provider was working in accordance with the MCA, and people had their rights upheld in this respect.

The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant Supervisory Bodies appropriately for a number of people. This meant people's rights were being upheld, and restrictions in people's care were lawful.

People told us that the food was very good and that they were offered choices. One person said, "Meals are very good." and another commented, "The food is very good. I am satisfied." A relative told us, "There is choice at breakfast and they always have diabetic choices." Health and social care professionals also commented positively on the food and drink choices and availability. Records showed people were offered a varied menu, with options available for people with specific dietary requirements. The provider regularly did surveys to seek people's views on the range of food and drink options, and feedback we saw on this indicated people were happy with the variety of meals. Where people expressed views about wanting different options, or different times for their meals, the provider ensured people's preferences were met.

People were provided with adapted cutlery and equipment to enable them to eat independently. People who needed assistance or encouragement to eat were provided with support in a discreet way. Staff knew who needed additional support to eat or special diets, for example, fortified diets or appropriately textured food and thickened drinks. Mealtimes were calm and people were not rushed. People were encouraged to have their meals where they wanted, and we saw there was a sociable atmosphere, with people chatting and enjoying each other's company. Staff had time to ensure everyone had support they needed, and people were regularly offered drinks and more food if they wished.

People who were at risk of not having enough food or drinks were assessed and monitored, and where appropriate, advice was sought from external health professionals. One person told us they had difficulty swallowing and their appetite was not as good as it used to be. They said staff supported them to have food that was a suitable texture, and offered encouragement to eat more. Staff and records confirmed this was the case, and professional advice had been sought for the person. This meant people were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

All staff had a probationary period before being employed permanently and undertook an induction period of training the provider felt essential to meet people's health and social care needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of standards linked to values and behaviours that social care and health workers apply in their daily working life. During their induction, staff worked alongside experienced colleagues to learn people's individual needs and preferences. The provider told us the deputy manager oversaw the training and assessing of new staff members' skills and knowledge. This meant the provider could ensure that new staff developed the skills and experience to meet people's needs.

Staff said, and records showed they received regular training in skills the provider felt necessary to maintain a good standard of care. This included moving and handling people safely, fire safety, tissue viability, medicines management, and safeguarding adults. One staff member described recent training in tissue viability as, "Very good, and useful." They described how this had raised their awareness and skills in supporting people to maintain healthy skin. The provider promoted daily short training sessions for staff to promote the delivery of effective care. Staff received external training in care (NVQ levels 2 and 3). A health and social care professional involved in staff training said the provider was proactive in supporting staff to achieve these qualifications, and spoke very positively about the care skills and attitude of staff The provider told us that a summary of staff training was given to the company directors to review and confirm that training was up to date.

There were regular staff meetings which enabled staff to discuss information relating to care. Staff told us, and records showed they had meetings with their supervisor throughout the year to discuss their performance and training. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues. Staff also confirmed they did not have to wait for these meetings to flag up any concerns or training needs. This demonstrated the provider ensured that all staff received training to enable

them to provide safe and effective care for people.

People felt confident staff would support them to maintain their health and enable them to access healthcare services when required. A relative said, "Staff will assist with appointments if family are not available." Health professionals spoke positively about staff contacting them in a timely manner to ensure people received prompt access to health services. Health professionals also commented that staff had a good level of knowledge about people's health needs, and one professional commented, "Staff always flag up concerns with me." They commented that staff were proactive in supporting people to maintain good health, and they were confident that staff followed any professional advice given. Staff were knowledgeable about people's needs in relation to external healthcare services, and records showed that people were supported to receive healthcare when this was needed. For example, we saw evidence from a relative who thanked staff for ensuring their family member received prompt healthcare when an issue was identified, commenting, "The speed of everybody's reaction reduced the risk of harm [to their family member]." Staff also told us they were trained to support people whose behaviour might present a challenge to others, and to ensure that they supported the person to access appropriate professional assessment and support. The provider told us they worked proactively with health and social care services, for example, chiropody services, GPs and the care home support team. This meant people were supported to access health services when needed and in a timely manner.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and demonstrated positive caring attitudes. People and their relatives consistently praised the quality of care. One person said, "They are caring. Their attitude, the way they speak to you. They treat me like they would treat a member of their family." Another person said, "They give us a 24 hour service." A relative told us, "The attitude of staff is great," and another relative described staff as, "Absolutely fantastic." A third relative spoke about how staff they had seen staff reassure people who were upset, saying staff were, "Very caring." We saw evidence in correspondence from relatives that they felt people were treated in a kind and caring manner, with one relative commenting that staff provided "Exemplary" care with, "Dignity, respect and love". Health and social care professionals gave positive feedback on the care and respect shown to people by staff. They felt people were treated as individuals, shown respect and care for in ways that ensured their dignity.

Staff explained to us they needed to take time to actively listen to what people were saying. One staff member said, "For new people [(new to the service]) it's a big scary thing to come into care, and it takes time for them to adjust. We need to respect that and support them." Throughout the two days of our inspection visit, staff supported people in a caring, friendly and respectful way. They spent time with people who appeared anxious or agitated. For example, we saw staff spend time with a person who was anxious. They spoke with them in a calm manner, and provided reassurance in a warm and friendly way. The person responded positively to this by giving the staff member a hug and became less anxious. We also saw staff take time to encourage people to participate in mealtimes. One person told staff they were not hungry, but acknowledged they did need to eat regularly. Staff sat with them and asked them about favourite foods. They talked together about cooking, and the person eventually asked the staff member to support them to the dining room. This meant the person was encouraged to eat in a patient and tactful way by staff. People and staff spoke with each other in ways that demonstrated staff knew and were interested in people's wishes, beliefs and interests.

People were encouraged to make their own choices and remain as independent as possible. One person told us, "They always tell you what they're doing. They let you do things for yourself which is best. It helps you keep your independence." A relative also commented on the staff's approach to promoting independence, stating, "They [staff] are very good and let [family member] do things but they're there straight away if they need anything." Staff were not simply task focussed when they spoke with people, and we heard people talking with staff about things that were meaningful and important to them. There was a strong person-centred culture in the service and staff demonstrated this throughout our inspection visit. Staff regularly asked people if they needed anything, and responded quickly to requests for support. People at the service made regular use of the garden, with one person telling us it was very important they got to go out for a walk every day. Staff ensured the person had full access to the garden, and regularly checked on them, bringing drinks and a newspaper. Staff told us that people had their own key-worker (staff) who provided additional support to people in their day to day life. For example, shopping, helping with correspondence and personalising their bedroom.

People were supported with their medicines and care needs in a dignified way. Staff understood how to

support people with dignity and maintained their privacy. For example, staff asked people about personal care in a discreet manner, in a way that maintained people's privacy and dignity. Staff described the importance of closing bedroom and bathroom doors when supporting people with personal care. One staff member said, "I always ask people's permission – please may I do this. For example, I check if people want me outside the door on inside to support them when they go to the toilet." During our inspection visit we saw staff demonstrate they provided care in ways that protected people's dignity and privacy.

The service was taking part in the local authority's Dignity Award campaign, and had achieved an award for this. Derbyshire County Council states, "A key test is if you're treating people with the same dignity and respect as you would want for yourself or your family." One staff member said, "I treat residents like I'd treat my own family," and we saw throughout our inspection visit that staff supported people with dignity, respect and warmth.

People were supported to spend private time with their family members if they wished. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting hours. One relative told us about the support their family member had from staff to celebrate their birthday, and said how positive this was. The provider ensured the service had enough quiet spaces, including lounges, people's own rooms, and garden areas to enable people to enjoy time with family and friends who were important to them. This showed people's right to private and family lives were upheld and their human rights respected.

People's right to confidentiality was respected by staff. Staff ensured that information about people's health and social care needs was stored securely. We observed staff discussing people's care needs in a quiet and discreet way. For example, two staff discussing support for people moved to another room to ensure they would not be overheard. Staff understood why it was important to maintain people's confidentiality, but they also demonstrated awareness of when it was appropriate and necessary to share essential information.

Good

Is the service responsive?

Our findings

People told us they enjoyed the range of activities offered and we were shown photographs of different activities throughout the year. One person said, "They do things to keep you occupied. I like the bus trips. I have my paper delivered every day, and other people like jigsaws and enjoying the garden." Another person spoke about their previous choir membership, and how they were able to continue to enjoy singing activities.

Staff worked with people and their relatives to ensure they were supported to maintain their hobbies and interests. Records showed there was a range of daily group and individual activities within the service. People were supported to participate in trips and events in their local community. The service's newsletter advertised a range of regular activities ranging from a canal boat trip and seaside trip, to evening entertainment and monthly themed dinners. People were supported to take part in weekly trips out, regular craft activities, and exercise classes suitable for people's different abilities.

One person told us about their church activities, and said they were still supported to do this. The provider had made arrangements for people to be able to continue to practice their faith, by making links with local religious groups, and putting on regular faith services. We saw staff from a local business had volunteered to build raised (accessible) beds in the garden to enable people to take part in gardening. The provider also participates every year in the National Gardens Scheme (NGS). The NGS raises money for charities involved in providing care and nursing. In June 2016, Coxbench Hall combined the NGS open garden day with a celebration of the Queen's birthday, inviting people, relatives and the public to visit. This meant the provider was actively involved in supporting people to continue to participate in the life of their local community.

People's care plans contained detailed information about their likes and dislikes, hobbies and friendships, and key information about life events. Where it was not possible to obtain this information from people directly, staff asked family members to provide information they felt was important about people's lifestyle choices. Staff demonstrated a good knowledge and understanding of people's personalities and lifestyle preferences. Records also contained information about people's communication styles, and we saw staff understood and used this guidance. For example, one person's verbal communication had deteriorated, and staff used picture cards to support their communication when making choices about care.

People and relatives felt they were involved in reviews or decisions about their care. Staff told us and care records showed this was the case. Relatives were involved in people's care planning where people consented to this, or where this was in people's best interests.

The provider held regular meetings for people and relatives to discuss the quality of the service, forthcoming events and improvements to care, and carried out surveys. Information was displayed in the service to say what issues had been raised and what action the provider was taking to improve the quality of the service. For example, a survey in June 2016 showed many people in the service did not know what their support plans were, so there was explanation given for this at a residents' meeting and information provided to people in the meeting minutes. The provider also sought the views of visiting health and social care

professionals about the service, and any compliments and concerns were used to improve the quality of care provided. The provider told us, and we saw that meetings for people and their relatives were frequently held in the evening to ensure relatives were able to attend.

People and their relatives knew how to make a complaint, and felt confident that any issues they raised would be dealt with appropriately. One person said, "I've never needed to complain. The manager would take it on board if I had a problem." The provider had a clear policy on complaints management and information about this was displayed in the service and provided for people and their relatives. We reviewed one formal complaint and saw the provider had dealt with this in a timely manner and in accordance with their policy and procedure. The registered manager confirmed that issues raised were dealt with as quickly as possible to prevent them from escalating to a formal complaint. This meant people and relatives were able to raise concerns and make suggestions, and the provider responded to improve the quality of care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's system for auditing records was not identifying gaps in the recording of health concerns and subsequent actions. On this inspection, we found that some of our concerns had been addressed. However, the system for auditing records did not identify issues associated with the management of medicines, or with the way risks were assessed and mitigated.

For example, one person's medicine doses were recorded differently on the pharmacy label and the provider's records. This meant the person was at risk of being given more than the dose prescribed. The provider could not always account for medicines people had been prescribed. Medicines were not consistently recorded as being received by the service, so there was a risk that medicines were not included in the provider's auditing. One of these medicines was subject to additional legal safeguards which were not being followed. We had concerns that one medicine was not being administered correctly as staff were crushing tablets. The MAR instructed that these tablets should not be crushed. The person's care records and risk assessments, and the provider's medicine checks and audits did not identify this as a risk. The lack of robust and accurate recording meant there was a risk that medicines would go missing, and that medicines would not be available to people when needed.

The audit system did not highlight that risk assessments were not reviewed and updated following accidents. The audit system failed to identify some risk assessments and care plans did not contain control measures to enable staff to provide care in a safe manner. For example, one person, who had three falls in July 2016, did not have a care plan developed to provide clear guidance for staff to mitigate the risk of avoidable harm. The monthly audits had not identified this omission. This meant the provider's system for auditing quality of care did not consistently identify areas for improvement so action could be taken. The registered manager understood their role and responsibilities in ensuring the service provided care that met the regulatory standards. This included notifying CQC of events as required. The registered manager attended relevant external forums to promote and support quality care provision. The registered manager had undertaken level 5 (diploma) training and the deputy manager was in the process of undertaking this training. However, the registered manager and the provider had not ensured the improvements they had made to the systems for auditing care were robust.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives consistently spoke highly of the registered manager and staff team. One person commented, "It couldn't be better in terms of staff." Another person commented, "Best place I've ever been to." A relative said, "[The registered manager] is lovely. It's well managed." Feedback from health and social care professionals was also very positive about the management of Coxbench Hall.

Staff told us they felt supported by the registered manager and by their colleagues. One staff member said, "I feel well supported." Another staff member commented, "I get so much support from [the registered

manager and deputy manager]. There's nothing I'm afraid to ask." Staff understood their roles and responsibilities, and felt supported and listened to if they raised concerns or had suggestions to improve care. Staff had regular supervision and staff meetings with the registered manager where they felt able to discuss concerns about the service and make suggestions. We saw the registered manager had an 'open door' policy and throughout our inspection, people, relatives, and staff came to speak with them frequently. We also saw that the registered manager and senior staff had the support of the provider on a daily basis. All the staff we saw demonstrated enthusiasm for their work, and many of the staff had worked for the provider for a number of years. When asked what motivated them to provide care for people, one staff member said, "I love what I do. It's like coming home here."

People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary. The provider also regularly sought people and relatives' views about the service, responded to comments and complaints, and investigated where care had been below the standards expected. Staff were encourage to make suggestions to improve the quality of care, and a suggestions box was located in a communal area of the service for everyone to use. The provider also told us that they offered incentives to people and relatives to encourage them to make suggestions. This assured us people, relatives and staff were able to make suggestions and raise concerns about care, and the provider listened and acted on them.

The provider had systems to monitor and review all aspects of managing the home. This included essential monitoring, maintenance and upgrading of the facilities. The provider employed maintenance staff to ensure that repairs were carried out quickly. There was a programme of maintenance of the facilities and grounds, including checks to ensure that equipment used was maintained as required by law. External professionals also carried out audits. For example, the service had been inspected by the local authority environmental health office and received the highest rating for the kitchen inspection. The company directors for the provider met with the registered manager every month to discuss and review the quality of care provided. The directors, registered manager and other senior staff in the service were also involved in carrying out audits, analysing the results, and taking steps to improve the quality of care.

We saw organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these, and were knowledgeable about key policies. We looked at a sample of policies and saw that these were up to date and reflected professional guidance and standards. The provider told us they worked with external specialist organisations to ensure they provided high quality care that was in accordance with current professional practice. For example, GPs and nursing professionals, the Care Home Advisory Service, employment law advisors, and health and safety advisors. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the manager would take appropriate action. This demonstrated an open and inclusive culture within the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems operating to assess, monitor, or improve the quality and safety of the service provided in the carrying on of the regulated activity. 17 (2) (a) The provider did not consistently assess, monitor and mitigate risks relating to the health, safety and welfare of service users. 17 (2) (b)

The enforcement action we took:

Warning notice issued