Holywell Park Limited

Holywell Park

Inspection report

Hodsoll Street
Ash-cum-Ridley
Sevenoaks
Kent
TN15 7LE

Tel: 01732822215
Website: www.holywellpark.com

Date of inspection visit:
02 May 2018
03 May 2018

Date of publication:
29 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Holywell Park is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Holywell Park is registered to provide accommodation and personal care for a maximum of 60 people. The home specialises in providing care to older people and to some people living with dementia. At the time of our inspection there were 49 people living in the service. Holywell Park is located near to Sevenoaks and is arranged over three floors.

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

There were not always enough staff to meet all the needs of people living at the service. Staff were not always available for people using communal areas. People were protected from abuse. Staff knew how to identify abuse, and had received training and support from management to report concerns. Risks to people and the environment had been identified and action was taken to reduce the potential of harm. People were protected from the risk of infection and the environment was clean. People received their medicines from competent staff in a safe way. Accidents and incidents were analysed by the registered manager for trends and patterns and lessons were learned when things went wrong.

The design and adaptation for the premises did not always meet the needs of people living there, but the registered provider was acting to address the concerns. Staff received the training they needed to meet people's needs. People's needs and abilities were assessed before they moved into the service and care was provided in line with current legislation. People were supported to have a balanced nutritious diet. Staff worked together across organisations to help deliver effective care, support and treatment. Staff knew about the Mental Capacity Act and used it when supporting people to make decisions.

People were treated with kindness, compassion and respect. They were offered emotional support when they needed it. People and their relatives were supported to express their views about their care and to be actively involved in making decisions about their support. People's privacy, independence and dignity were promoted and respected.

Not all people received the care they wanted or needed to meet their needs. Not all staff were aware of the needs of people because care records were not always accurate and up-to-date. People and their relatives were confident to raise concerns or complaints, but these were not always recorded accurately. We have made a recommendation about this. People were supported at the end of their life to have a comfortable, dignified and pain-free death. Staff worked closely with the local hospice and palliative care team.

Governance systems were not always effective in ensuring that shortfalls in service delivery were identified

and rectified. Audits had not been effective in identifying the issues we identified during this inspection. The registered manager had an oversight of and reviewed the daily culture within the service, including the attitudes and behaviour of staff. The management team encouraged transparency and honesty within the service. People, their families and staff were encouraged to be engaged and involved with the service. The registered manager had developed links with the local community.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the reports.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough care staff deployed in the service to support people to stay safe and meet their needs.

People were kept safe from the risk of abuse.

People's medicines were managed safely.

Staff were recruited safely.

The registered manager learnt from lessons when things went wrong.

People were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The accommodation was not always designed to meet people's needs and expectations.

Care and treatment was delivered in line with best practice guidance.

People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

People received care and support in line with the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were supported to express their views and be actively involved in making decisions about their care and support.

People's privacy, dignity and independence were respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was responsive to their needs.

People's concerns and complaints were listened to but were not always responded to in order to improve the quality of care.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Governance systems were not always effective in ensuring any shortfalls in service delivery were identified and rectified.

The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes and behaviour of staff.

Management encouraged transparency and honesty within the service.

People and staff were encouraged to be engaged and involved with the service.

Holywell Park

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 registered persons continued to meet 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.

Due to technical problems, we did not ask the provider to complete a Provider Information Return. We took this into account when we inspected the service and made the judgements in this report. A Provider Information Return is information we require providers 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 also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 2 and 3 May 2018 and the inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

During the inspection we spoke with eight people who lived in the service and with six relatives. We also spoke with four members of a care staff, a nurse, an activities coordinator and two kitchen staff. In addition, we met with the registered manager and the registered provider. We observed care in communal areas and looked at the care records for three people who lived in the service. We also looked at records that related to how the service was managed including training, staffing and quality assurance.

In addition, 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 speak with us.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they thought the service provided at Holywell Park was safe. One person told us, "My family don't have to worry about me here. I was always having falls at home." Another said, "I can ring my bell for help any time of the night or day and someone comes to me." A relative said, "They told us how they wanted to look after mum and they've done well. She feels safe and happy." However, we did not always find the service safe.

There was not always enough staff deployed to meet people's needs. The registered manager used a dependency tool to determine the number of staff required on each shift. This tool considered the needs of people at the service, and rotas showed shifts were staffed with the expected number of staff. However, the layout of the building meant people using the communal areas were not always able to easily attract the attention of staff when they needed support. There were three communal lounges in the downstairs area of the service, and people choose which room they sat in. Staff would periodically check if people needed support, but there was not a permanent presence in each room. We saw one person with a physical disability wanted to use the toilet and was unable to do so independently. Since there were no staff available to ask for support from at the time, we saw them crawl across the floor towards the entrance hall of the building to attract attention of staff. Some relatives we spoke to also raised similar concerns. One told us, "My mum isn't incontinent but needs help getting to the toilet. One day when I came to visit she told me she'd soiled herself because nobody was available to help. I needed to get someone to clean her." Another said, "Mum can get to the toilet by herself but she tells me she worries about others. She said she wants to take them herself but I told her not to." We spoke to the registered manager and registered provider about the concerns. They told us they were unaware of the concerns raised but were in the process of reviewing the deployment of staff throughout the service in order to meet people's needs in a timely way. This had included the organisation and deployment of staff during lunch but had not yet taken into account communal areas. They told us they would address the deployment of staff in communal areas as a matter of priority.

The failure to deploy sufficient numbers of staff to make sure they can meet people's care needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Other parts of the service were sufficiently staffed. The building was split into two units, with each unit having a dedicated nurse, a team leader, senior care staff and care staff. A head of care oversaw both units and the registered manager told us they were in the process of recruiting a clinical lead to oversee the nurses and to assist with more detailed person-centred care planning. They had also increased the number of nurses on the night shift based upon changes to people's needs. We saw staff were able to meet the personal care and nursing needs of people, such as bathing or showering. Staff told us, and records confirmed, that the number of people with pressure areas or ulcers had significantly reduced since the registered manager and had been in post, which was an indication that there were enough staff to meet people's needs. Each person had a call bell in their bedroom, which could be used to call for assistance. Records showed staff were responding to people in their rooms in a timely manner in both day and night. Since the change in registered provider, the registered manager had recruited more permanent care staff to

reduce the reliance on agency workers which meant people were supported by staff they knew better. One staff member told us, "Things are definitely getting better. New girls have come in and they've been brilliant." The new staff were recruited in a safe manner. Pre-employment checks were made. Staff completed Disclosure and Baring Service (DBS) checks to ensure that they were suitable to work at the home. DBS checks identified if prospective staff had a criminal record or were barred from working with people that need care and support. References were sought and checked. These checks ensured that staff were suitable people to be employed at the service.

People were protected from abuse and avoidable harm. Staff were trained in how to identify different types of abuse and the steps they needed to take if they had any concerns. Staff told us they felt confident to raise concerns if they needed to. One staff member said, "I would speak to a senior member of staff or the manager if I saw anything but I've not needed to yet. We recently had some new training which was really helpful." Staff knew about how harm could be caused by discriminating against people in relation to their protected characteristics under the Equality Act, such as their sexuality or religious or cultural beliefs. A staff member told us," Everyone is different and we're taught to respect that." A whistleblowing policy was available to staff and the staff said they felt confident that the registered manager would listen to any concerns they had. The registered manager worked openly and transparently with the local authority when carrying out safeguarding investigations, and feedback we received from the local safeguarding team was positive. The registered manager also informed the Care Quality Commission about concerns in a timely manner.

Where risks to people were identified staff acted to reduce the chance of harm whilst supporting people to be as independent as possible. One person had been assessed as being at risk of falling when bathing, so a measure was put in place where they would be supported by two members of staff to reduce the risk of injury. The person told us that although they needed the support, they were also encouraged to take part in washing themselves rather than having care staff do it for them. When another person was identified as being at risk of falling when walking throughout the building, records showed staff were advised to ensure their walking frame was within arm's reach when they were sitting in a chair and to encourage them to use it. Plans were in place to support people in the event of an emergency. Each person had a personal emergency evacuation plan (PEEP) which provided guidance to staff on the support they required if the building needed to be evacuated in the event of a fire. This considered the persons' dependency level, their physical capability and how they were to be escorted from the building. Staff were trained to use fire evacuation equipment such as fire extinguishers, and took part in fire training and evacuation drills. Maintenance staff tested fire alarms weekly. The service had arranged for a thorough fire risk assessment of the building and recommendations, such as the installation of additional smoke detectors, were followed up. Other checks were carried out to ensure the environment and equipment was safe for people. Water temperatures were checked in every room to protect people from the risk of scalding, and a recent external legionella risk assessment did not raise any concerns. Gas safety certificates showed equipment in the kitchen was safe to use. Hoists were serviced every six months, and people's wheelchairs were checked monthly. Electrical equipment brought into the service when someone moved in was checked by staff to ensure it was safe.

People received their medicines safely. Any support people needed with their medicines was recorded in their care plan and if support was required it was provided by a registered nurse. There were two nurses on shift at any one time, and feedback from the nurses was that this was an adequate number to meet the needs of everyone. Nurses wore a coloured tabard when administering medicines to let other staff members know they should not be interrupted. Most medicine was supplied in blister packs service from a local pharmacist. Nurses checked medicine records when supporting people to make sure the correct doses were given, and records we saw were accurate and complete. When 'as required' medicines were prescribed by

the doctor, such as paracetamol, these were stored safely. Reasons for giving these medicines were recorded so staff could check for patterns, and the GP was contacted if people were taking them more frequently than expected. We saw people being offered and declining these medicines during lunchtime. One person's records showed a medicine review was requested by a nurse for one person who had not needed their 'as required' medicines for some time, and this prescription was subsequently stopped. Medicines were stored in a locked room which had its temperature monitored daily to ensure it was within an acceptable range. Fridge temperatures were also monitored daily. When a higher than expected temperature was recorded, the nurse arranged for the fridge to be checked by the maintenance team, and a broken seal was fixed on the same day. People who lacked capacity to make decisions about their medicines received them in accordance with the Mental Capacity Act. Best interest decisions were made considering feedback from relevant people such as family members or the GP. When people declined to take their medicines, nurses took appropriate action. One nurse told us, "If someone refuses I'll go back a bit later to encourage them. One lady recently spat out her medicine three times in a row so I arranged for a review from the GP."

People were protected by the prevention and control of infection. The service had a policy in place which followed nationally recognised guideline, and staff followed the policy to ensure people were kept safe. We saw staff using personal protective equipment (PPE) such as, gloves and aprons when supporting people and there was an enough hand sanitiser situated throughout the home for staff, people and visitors to use. As part of the new quality assurance procedures being implemented by the registered provider we saw there were weekly and monthly audits taking place to measure the cleanliness of the service and to identify shortfalls. People and their relatives told us they thought the environment was clean and fresh. One relative said, "The staff do a good job in keeping it clean. It's neat and tidy."

The registered manager took steps to make sure lessons were learned when things went wrong. Staff understood the importance of reporting incidents and near misses such as when a person fell, or when staff noticed bruises or other wounds. The registered manager kept a record of these incidents, and monitored them to look for trends and patterns. Records showed when one person fell twice in a short period of time their care plan was reviewed and changed to help them stay safe. Lessons learned were shared with staff during team meetings and supervisions.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the service was effective in meeting their needs and they had a good quality of life. One person said, "I like the food but if there's nothing on the menu they'll make me something else." A relative told us, "Staff are lovely. They know mum and know what she likes and how she likes it to be done." Despite the positive feedback we did not find the service to be consistently effective.

People's needs were not always met by the adaptation and design of the service. People could choose how their rooms were decorated and could bring in their own furniture from home to help them feel more comfortable. Rooms were large and spacious and there was plenty of communal space for people. There was a large garden for the use of people and their relatives. However, the registered provider had acknowledged that signage and decor of the home had not been designed with the needs of people with dementia in mind, and was in the process of addressing concerns they had identified. These included plans to repaint all walls, with different colours on different floors to help people with dementia better navigate throughout the home. There were also plans to remove patterned carpets and to replace them with wooden flooring and to improve signage throughout the service. Some of this work was in progress at the time of the inspection. Feedback from relatives about the plans was positive, with one telling us, "It's already made such a difference to the entrance, it's so much brighter. Mum is very much looking forward to the changes." These changes needed to be embedded to ensure they supported people with dementia.

People's needs were assessed before they moved into the service. The registered manager met with the person and their family to help determine if the service could meet the needs of the person. The assessment considered areas such as the persons' physical capabilities, their mental wellbeing, sleeping patterns and nutrition and hydration needs. Protected characteristics under the Equality Act such as a persons' religious beliefs and ethnic origin, were recorded so staff knew how people wanted their care to be provided.

Staff received training so they could meet the needs of people effectively. The registered provider had carried out an analysis of training staff required, and there was a plan which ensured all staff were up-to-date with their training. When areas of improvement were identified these were followed up with support for staff. For example, when it was noted that some staff found it difficult completing a particular form, additional training was provided. Some training was provided face-to-face, and recent sessions included basic emergency aid, manual handling, dementia and safeguarding. The registered provider sought feedback about the sessions, and records showed staff found the training helpful and relevant to their role. Other training was carried out online and the registered provider supported staff who needed help using computers. Staff were encouraged to further develop their careers and the registered provider was in the process of gathering interest from staff about further qualifications such as a diploma in Health and Social Care. Staff told us they received regular supervisions from their seniors. One staff member said, "It's pretty good. We can talk about issues we have."

People were supported to eat and drink enough to maintain a healthy, balanced diet. We saw people had a choice of what to eat at breakfast, with some people choosing to have a fried breakfast and others eating cereal. At lunch people choose from options, and the chef told us they sought the opinions of people when

drawing up the menu. People choose items off the menu, such as salads or jacket potatoes, and we saw one person asking for a ham omelette. The food being served looked appetising and we heard people commenting on it in a positive manner. There were enough staff at lunch time to support those who needed support with eating. Where people were not able to use cutlery independently, staff supported people at eye level and explained what food they were giving them in a dignified way. People were given time to eat and were not rushed. We saw one person finding it difficult to make a choice about what to eat. Staff patiently showed them different dishes until they made up their mind. Staff supported people with complex health needs. Guidance from Speech and Language Therapists (SaLT) was sought for people who had been identified as having difficulty swallowing. This information was passed to kitchen staff to ensure food was presented correctly and safely. Other people who were at risk of malnutrition or dehydration had their food and drink intake monitored regularly.

People received coordinated care when they moved between services. When people needed medical treatment in hospital, written information about people's care needs and medicines was passed to hospital staff, and care staff would attend appointments so information could be personally passed to healthcare professionals. If people had a longer stay in hospital the registered manager would carry out a detailed assessment before they returned to be certain staff could still meet any change of need. When people stayed at the service for a short period of time, such as for respite, nurses sought to temporarily register the person with a GP close to the service to more effectively manage any changes in their health.

People had access to health care services. Nurses had close working relationships with the local GP surgery, and a visiting GP told us, "The information is well presented and the nurses refer to us when they need to. They're on the ball." Records confirmed people also had timely access to dentists, specialist nurses and dieticians. Relatives were kept informed of health appointments. One relative told us, "Communication is good."

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 law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation 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 Mental Capacity Act 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found staff to be familiar with the MCA and were able to describe how they sought consent from people who may find it difficult to communicate. For example, one member of staff said, "One man will turn his head, I know that means he doesn't want a shower." When necessary, senior staff carried out mental capacity assessments. If a person did not have the ability to make a decision independently then decisions were taken in people's best interests and involved their families and other professionals. DoLS applications were made to the local authority by the registered manager, and people's records showed any conditions of the applications were being met.

Good

Is the service caring?

Our findings

People and their relatives told us they thought they were cared for at Holywell Park. One person said, "They are lovely here." Another said, "Nothing is too much trouble." A relative said, "I think the carers are extremely caring. Not once have I heard anyone sounding irritated." Another said, "The carers are very impressive and caring."

People were treated with kindness and were offered emotional support when they needed it. Staff communicated with people in a compassionate way, getting down to their eye level and speaking to people using their name. We heard staff reassuring one person whilst supporting them to move between their chair and wheelchair, explaining the process to them and making sure they were ready before helping them to move. We saw another person had fallen asleep in a chair within the communal lounge. A member of staff carefully covered them with a blanket to keep them warm. Some people had difficulty with hearing, and we saw staff taking their time to speak slowly and clearly to help ensure they were being understood. Staff knew people and their needs well. One relative told us, "Staff have learned mum's patterns, and know the signs to look for. She doesn't get as upset now as she did when she first moved in, or even before she moved in here." Staff could tell us about people's personal histories and backgrounds, such as where they used to work, their interests and about which family members were important to them. Staff used accessible ways to communicate with people. For example, kitchen staff showed people pictures of food to help them make a choice at lunchtime. When one person couldn't make a choice using the pictures, kitchen staff brought out two plates of food. The person could choose which meal they would prefer.

Where possible, people could express their views and were involved in making decisions about their care and support. People's care was reviewed at least annually by senior staff, or when changes in a person's needs meant their care and support needed to change. Most people had family members or friends to support them articulate their wishes if they were not able to do so themselves. Family members confirmed they were regularly consulted about the care being provided. One family member said, "We chat with the senior carer, and they tell us what they are planning to do. We had a formal review pretty early on." Family members told us they were free to visit any time of day or night, and staff helped them feel welcome. We heard staff speaking to family members in a respectful manner. One family member said, "We come and go as we wish. The girls always have time for my questions." The registered manager was also aware of their responsibilities of involving external advocates for people who did not have access to family support. Advocates are independent of the service and who can support people to make decisions and communicate their wishes.

Staff respected people's dignity and privacy as much as they could. Staff told us they were mindful not to speak about people's private affairs, such as their health conditions, in front of others. People were treated with dignity when they were receiving personal care. One family member told us, "Carers will knock before they come into the room." A member of staff said, "We shut the door when we help someone with having a bath or shower. And shut the curtains. I'll cover someone's lower half when I'm washing the top too." People's care records were kept safe in a locked cupboard and only used by staff when necessary. People were supported to be as independent as possible. We saw people walking freely around the home without

being unnecessarily restricted. People's preferences and choices were taken into consideration when scheduling staff, such as if they wanted to be supported by a male or female staff member. People were supported by staff who welcomed and appreciated diversity, with one telling us," People are free to be who they want to be. That doesn't stop just because they move into a home."

Requires Improvement

Is the service responsive?

Our findings

People told us they thought the support they received at Holywell Park was responsive to their needs. One person told us, "There's always something on here. You can do something every day if you want." Another said, "My bed sores which I had when I came here have gone. I get personal care twice a day and they don't leave me alone for long." A relative told us, "Her nails are done, she's always in her own clothes. She's put on weight too." Another relative said, "I needed to make a complaint and the manager responded quickly." However, we did not always find the service to be responsive to the needs of everybody.

Staff were not always clear about the needs of people they supported. This meant people did not always receive the care they wanted in the way they wanted it. We spoke to staff about one person living at the service. Care staff told us the person would be more settled during the day if they had a bath or shower first thing in the morning. They told us this did not always happen, meaning the person may be anxious and upset for the rest of the day. We spoke to a senior staff member who said they expected the person to be offered a bath every day, and if they person did not want to staff should record this in their care records. However, the person's care plan indicated they should be offered only two baths a week. Care records showed they had only received one bath a week for the two weeks prior to the inspection, including on the morning of the inspection, with no indication as to why more baths had not been given or offered. We spoke to the registered manager about our concerns, who said they had identified shortfalls in the care planning for people in the service and were in the process of introducing more robust care plans which would provide clearer guidance to staff.

We recommend the registered manager seeks guidance from a reputable source in the continued development of detailed, accurate care plans.

Other people received care and support that met their needs. Each person had their own care plan and the records we saw were in the new format being introduced by the registered provider. They indicated how the person wanted to be supported, and included looking at all areas of their daily living and seeking feedback from the person and their family about their needs and the care they required. There was information about the care people wanted and needed and the way they would like this to be provided. People were supported to take part in activities that were appropriate to them. The service employed three full-time activity coordinators who organised activities based upon people's interests. On the day of the inspection one person was being supported to visit a local pub, whilst others were playing a game of cards. People were positive about the activities provided. One person said, "They've just started a keep fit class, which I help with as well." A relative said "Mum prefers to spend time in her room but they still go to sit with her."

People and their relatives told us they were aware of how to make a complaint, but outcomes were not always being recorded consistently. One person told us of a number of complaints they had raised with the registered manager about the support provided to their relative, and how they were not always responded to appropriately, and they did not always feel listened to. We spoke to the registered manager about these concerns, who told us most of the complaints were verbal and they had not been recorded. This meant complaints could not always be used as an opportunity to learn from to help improve the service. Other

people said if they had needed to make a complaint, they were responded appropriately and in a timely fashion. One relative said, " If we have any issues we speak to the manager and she'll sort it."

We recommend that all complaints are recorded to show the nature of the complaint, how it was investigated and the outcome.

People were supported at the end of their life to have a comfortable, dignified and pain free death. Senior staff drew up a care plan with people and their families which considered their preferences and any cultural needs they may have at the end of their life. This included whether they wanted to be at hospital or stay at home and how they and the family would like the environment to be. Nurses worked closely with the GP and the local hospice to ensure people had access to 'anticipatory medicines'. These are medicines that can be used at short notice under a doctor's guidance to manage pain so that a person can be helped to be comfortable. Nurses closely monitored people's health needs and arranged timely support from the GP or hospice when necessary. People's families were supported and were encouraged to stay at the service for as long as they wished. They were offered meals and emotional support from staff. One family member told us, "They were fantastic when dad died. They gave him the upmost care and made a fuss of him."

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff told us they thought the service was well-led. One relative told us, "The manager is helpful and friendly." A member of staff said," There have been a lot of changes since the new manager came in, but things are settling now."

Governance systems were not always effective in ensuring that shortfalls in service delivery were identified and rectified. The registered manager carried out a quarterly audit to review the quality of service delivery. This audit looked at the home management and communication, person centred care planning, infection control, medicines, safeguarding and staffing. Where areas of improvement were needed, progress was recorded on an action plan and steps were taken to address them. For instance, one audit identified shortcomings in the quality of care planning, with the action plan indicating all new care plans to be put in place by August 2018 in conjunction with additional staff training in how to write a person centred plan. Another audit identified shortfalls in recording the outcome of GP visits. Records showed the recording had improved. However, the audits had not identified some of the areas of improvement we saw during our inspection, such as with staff deployment and the management of complaints.

We spoke to the registered manager about our concerns. They told us the registered provider had drawn up an overall quality assurance action plan which looked to build upon the audits currently in place to further improve the service. This included looking at how they would improve their understanding of what people wanted of the service; how they were to act on customer feedback; the introduction of more detailed quality audits; how they could improve people's safety and improving management practices. For example, there were plans to introduce a quarterly resident and relative feedback survey and bi-annual resident and relative meetings to gain the opinions of people to help drive improvement. Another example was the registered manager and quality assurance manager were planning to log all complaints on a tracker, and carry out a monthly review of complaints and compliments to look for trends and patterns.

People and staff were involved in developing the service. A resident survey had taken place and the results were generally positive. However, it identified that the majority of residents completing the survey were unaware they had a care plan about themselves. An action from this survey was for staff to encourage people to read through and comment on their plan. The registered manager held meetings with staff to discuss service improvements and gain feedback about working practices. They also held exit interviews with staff when they left the service and fed comments back to staff to help with team building.

The registered manager told us they spent some time each day observing how staff interacted with each other and with people living at the service. They told us, "I want staff to provide the best care they can." They said they tried to treat people fairly, telling us, "I have high expectations and if I think someone needs to improve I'll take them aside and try to teach them what I am wanting from them." Staff told us that morale had been improving since the new registered provider had taken over the service. One staff member told us, "Things are getting better. I think they listen to me if I make a suggestion." Another said, "A lot of new staff came in and that rocked the boat but everyone is getting along now and we don't seem to use agency staff anymore." Staff said they felt proud to work at the service, and were treated fairly through the period of

transition.

The registered manager and the registered provider were aware of their responsibility to comply with the CQC registration requirements. They had displayed both in the service and on their website the quality ratings we gave at our last inspection. They had notified us of events that had occurred within the service so that we could have oversight of these to ensure that appropriate actions had been taken. They were also aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and their representatives in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. We saw that any incidents that had met the threshold for Duty of Candour had been reported correctly.

Whistleblowers are people who raise their concerns in a certain way and may receive protection in any employment dispute. All organisations that provide care must have whistleblowing procedures and must make them available to their employees. Staff said they were aware of the whistleblowing procedure. They said they would be confident to raise concerns if they had them both internally to senior staff or externally to organisations such as the local authority or to CQC.

The registered manager had developed good working relationships with health professionals for the benefit of the people living at the service, including care managers, local GPs and other health professionals such as podiatrists and occupational therapists.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to deploy a sufficient number of staff to meet people's care needs. Regulation 18 (1)