Mr & Mrs G Butcher

# Lyndhurst Park Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 inspection was unannounced and took place on 23 and 24 November 2016.

Lyndhurst Park Nursing Home is registered to provide accommodation and nursing care for up to 27 people including people who require respite care. The home specialises in the care of older people. Some people at the home have complex needs or dementia and as a result have limited communication skills. At the time of our inspection there were 27 people living at the home. The home is a large building over two floors. There are communal lounges, a dining room and an indoor pond.

The home 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. They worked alongside the provider to manage the home on a daily basis.

People and relatives told us they felt safe. We found improvements could be made with some of the medication procedures in the home. Nurses knew people's administration preferences. However, staff did not have guidance for people who needed medicines 'as required', medicines were not always stored securely and some medicine administration seen was not safe.

Staff had a working knowledge of infection control.

The provider and staff understood about Deprivation of Liberty Safeguards (DoLS) and the process to follow to make sure people's human rights were respected. People who lacked capacity had decisions made following the code of practice.

Quality assurance systems did not identify all concerns found on the inspection. There were limited records to demonstrate learning from issues found by the management. When shortfalls had been identified they had not always resolved them.

A safe recruitment procedure was not always being followed because staff had not always received complete checks before starting to work with people.

Staff knew how to recognise and report abuse. They had received training in safeguarding adults from abuse and knew the procedures to follow if they had concerns. However, one concern found had been raised with the local authority.

Staff were supervised informally and had annual appraisals. They told us they received enough training to meet most people's needs.

People were supported by sufficient staff to enable them to take part in a range of activities according to their interests and preferences. There was a low staff turnover which meant people received consistent care and support. The registered manager and provider were currently recruiting more staff because they had identified people's needs were changing.

People's health care needs were monitored and met. Staff and the registered manager made sure people saw the health and social care professionals they required and implemented any recommendations made which people agreed to.

Staff supported and respected the choices made by people. People's cultural and religious diversity was respected. People had a choice of meals, snacks and drinks and most people told us they enjoyed the food. People who required special diets received them and staff understood about special diets to meet people's care and health needs.

There were systems in place to manage complaints and the registered manager and provider demonstrated a good understanding of how to reduce the likelihood of them.

People and their relatives thought the staff were kind and caring and we observed positive interactions. People's privacy and dignity was respected by staff.

Staff had good knowledge about people's needs. Their care plans contained information about end of life care choices which helped to ensure best practice for people when nearing the end of their life. The needs of the people were reflected in their care plans.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People's medicines were not always managed safely because there was a lack of guidance for staff when people needed medicines 'as required' and medicines were not always stored securely.

People were not always protected from risks around the home.

People were protected from abuse and avoidable harm by staff who understood the process. However, one concern found had not been raised with the local authority.

Risks were identified and managed in ways that enabled people to make choices and participate in activities they enjoyed.

People were kept safe and had their individual needs met because there were sufficient numbers of suitable staff deployed.

### Is the service effective?

**Good**

The service was effective.

People who lacked capacity had their human rights considered in line with current legislation.

People were supported by staff who received on-going training to make sure they had the skills and knowledge to provide effective care.

People were supported to see appropriate health care professionals to meet their specific needs.

People made decisions about their day to day lives and were cared for in line with their preferences and choices.

### Is the service caring?

**Good**

The service was caring.

People told us that they were well looked after and we saw the

staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected by staff.

People's religious and cultural needs were considered.

## Is the service responsive?

Good

The service was responsive

People's care plans were detailed and they were personalised to cover all aspects of their care and needs.

People participated in activities and where possible the activities team tailored them to meet individual preferences.

People received care and support in line with care plans and staff were familiar with the information in the care plans.

People knew how to make complaints and there was a complaints system in place.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not always fully protected from risks because the systems to monitor care were not always effective.

People were not always kept safe because the provider's policies and procedures were not in line with current national guidance and legislation.

People were supported by staff who understood the provider and registered manager's vision for the service.

People's care was delivered by staff who understood their lines of accountability and provided support.

The care for people was improved because the provider and registered manager built positive links with other agencies and focussed on their own personal development.

The provider and registered manager focussed on their personal development and developing links with other agencies.

# Lyndhurst Park Nursing 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 23 and 24 November 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor nurse. The specialist advisor nurse had a background in and experience of working with older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We spoke with eight people that lived at the home in detail, three relatives and two health and social care professionals. We had informal conversations with other people at the home because they had limited communication skills. We spoke with the provider, the registered manager and six members of staff including kitchen staff, activities staff and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people could not talk with us. Following the inspection we spoke to two health and social care professionals on the telephone and via email.

We read eight people's care records and observed care and support in communal areas. We read five staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, staff and resident meeting minutes, medication files, people's questionnaires, environmental files and a selection of the provider's policies.

Following the inspection the provider sent us further details including a risk assessment, investigations to concerns raised during the inspection and minutes from a best interest meeting.

Requires Improvement

# Is the service safe?

## Our findings

The service was not always safe. People told us they felt safe at the home and with the staff who supported them. However, improvements were needed with the management of medicines, infection control, risk management processes and safety checks on equipment. Some people were prescribed 'as required' medicines used to alleviate pain or reduce anxiety. There was a risk some people with limited communication could not inform staff when they required this type of medicine. Care plans had no information to inform staff. For example, one person required a medicine when they became anxious and their care plan said, "Refer to [medicine's name] protocol". There was no further protocol to provide guidance for staff. Staff told us they just knew when people needed the medicines. The registered manager told us they would make sure these were put in place following the inspection.

We observed parts of two medicine rounds. The nurses administering medicines knew people's personal preferences for taking medicines. For example, whether they wanted them one by one or all together. They asked if people required pain relief and checked people had swallowed their medicines before signing administration records. On one occasion when a tablet was dropped on the floor a nurse picked it up and correctly disposed it. However, the administration we observed was not always considering how to reduce the spread of infections. For example, on one occasion a nurse used their fingers to remove tablets from a person's monthly medicine pack. Tablets should be dispensed directly into medication pots where possible to avoid contamination. On another occasion a tablet was dropped on the floor by the nurse. A member of the inspection team prevented the tablet from being administered because the tablet was going to be administered. The registered manager told us staff competency for administering medicines was assessed through an informal observation process; there were no records to demonstrate this had been completed. Following the inspection the provider informed us they were now formally assessing the competency of all staff who administered medicines to reduce the likelihood of poor practice.

One person did not receive medicines administered in line with instructions given by the provider. The person's care plan read, "It has been decided by [name of health professional] to give [name of the medicine] covertly in food or drink". One nurse was seen mixing the named medicine with another medicine in a glass then administering it to the person; there was no food or drink. In addition, this practice had not been checked with the pharmacist in line with the provider's policy. This meant there was a risk the medicines could have their integrity damaged and harm the person or not be as effective.

Medicines were not always found to be stored securely. Medicines requiring additional security were appropriately stored. However, we found other medicines were not. At the beginning of the inspection we found an unattended, open medicine trolley with the keys still in the lock; it was located in the hallway outside some people's bedrooms. Some people who live in the home were independently mobile; others were living with dementia who could get confused and take medicine. Following the inspection the provider told us they had fully investigated the incident. The nurse explained they were not gone long because they were attending to an ill person who was in distress.

Staff knew their role in preventing the spread of infection. Personal protective equipment, such as gloves

and aprons, were available for staff to use. Staff used them when providing intimate care and when serving food. The nurses correctly disposed of any used needles in special bins to prevent the spread of infection.

In February 2016, the provider had an external company complete a fire safety check for the building. This included checking the magnetic system which was in place to ensure fire doors closed automatically during a fire. Recommendations had been made including putting labels on existing fire doors so they were kept closed and changing some standard doors to fire doors. At the inspection, one door had not been replaced and two doors did not have labels. The labels were to identify fire doors which should be kept shut at all times. We spoke with the provider who was unsure whether the remaining door needed replacing. They could not find the stickers previously purchased for the doors. Following the inspection the provider ensured the labels had been stuck to the fire doors and showed us photographs of the shut doors. We contacted the fire and rescue service to share our concerns about fire safety.

Staff told us, and records seen confirmed, staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. One staff member said, "I have had safeguarding training". One incident was recorded where a fork was thrown by a person across the dining room narrowly missing other people and staff. We spoke with the provider who said because it missed people they did not need to report it after they had investigated the incident. Staff told us they had spoken with the nurse in charge about this incident. The registered manager and provider had made sure the person who threw the cutlery was reassessed by health professionals. However, the local authority safeguarding team and CQC had no knowledge there had been a concern with this person. By not reporting alerts no external monitoring could occur to make sure people were safe from abuse.

There was a recruitment procedure in place for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. All staff confirmed they did not start work until all the checks were complete. However, the provider had not ensured all checks were complete in line with current legislation. For example, two staff members did not have a full history of employment. The provider told us they thought one member of staff had been a parent and the other member of staff had references from their most recent employers. We spoke with the provider and they took immediate action to resolve the gaps found.

People and visitors told us they felt safe. One person told us "I feel safe". Other people said, "Yes" when they were asked if they felt safe. One visitor said, "I definitely feel my relative is safe here at all times". A member of staff told us to keep people safe they "Make sure they can't hurt themselves".

Care plans contained risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves and others. Others risk assessments were in place to identify ways to reduce the risks of pressure sores, falls and malnutrition; staff were aware of these. They were reviewed monthly and were amended if the risks to people changed. For example, one person's mobility needs had changed and the risk assessment reflected this. However, on occasions there were inconsistencies because care plans did not provide enough details or were not in place for identified risks. For example, one person had bed rails on their bed with no risk assessment in place. There was no information in their care plan about how to use the bed rail to prevent harm to the person. We spoke with the registered manager and they completed a bed rails risk assessment during the inspection to inform staff how to reduce the risks. Their relative was present during the inspection to confirm they were involved in the decision.

People were supported by sufficient numbers of staff to meet their care needs. Most people, visitors and staff felt there were enough staff. One person was asked if there were enough staff and said the levels were

"Ok". Other people had staff checking they were alright and coming if they called. Call bells were answered promptly. At meal times support was provided to those who required help eating. Visitors told us, "There always seems to be enough staff" and "There is definitely enough staff around, including weekends". Some staff told us, "Yes, we have enough staff" and "We have enough staff. People's needs are being met". Three people informed us there were times of the day when they had to wait longer for staff. For example, in the morning when people were getting up. The PIR said, and we saw, there was a low staff turnover which meant staff knew people well and there was consistency in staffing.

Good

# Is the service effective?

## Our findings

Some people at the home lacked capacity to make all decisions for themselves. 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. Decisions made in a person best interest consider what the person would choose if they had the capacity. We checked whether the provider was working within the principles of the MCA and they were following the principles of the MCA. For example, one person lacked capacity due to an illness and regularly refused their medicine. As a result they had been receiving them hidden in food and drinks. Their care plan detailed the reasons why medicine administered in this way was necessary and they had consulted the person's doctor and relatives. A second person was at risk of becoming agitated and displayed behaviours which were challenging towards other people. To alert staff when they got up they had a piece of equipment which sounded an alarm. We saw this being used on their arm chair during the inspection. The person's relatives, who had the correct decision making power had been consulted about this decision.

People can only be deprived of their liberty so that they can 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 and they were. Applications had been made for three people living at the home because they were unable to leave the building unaccompanied and they required constant supervision. One person was deemed to have capacity by the local authority so no further action had been taken. Another person's DoLS had just been authorised and the provider were waiting for the paperwork. The third person's application was still with the local authority. There was a system in place to monitor any DoLS and record if further action was required such as renewals.

People received care and support from staff who had some skills and knowledge to meet their needs. Staff told us, and records showed they had received a range of training. One staff member said, "We get quite a lot of training. I've recently done documentation training and I'm due manual handling later this month". Other staff told us about training they had received including fire safety, eating difficulties due to problems swallowing and safeguarding. The provider identified when staff had different roles in the service they required specific training. For example, the maintenance person had received training about maintaining a clean water supply and a member of kitchen staff had training in good food hygiene practice. However, there were occasions when additional training was required. For example, with mental capacity and medicine management.

People were supported by staff who had undergone an induction programme which gave them the basic skills to meet people's needs. New members of staff completed an induction including shadow shifts. The provider chose not to use the Care Certificate as part of the induction of new staff. The Care Certificate is a set of standards created by Skills for Care which all health and social care workers should follow in their

daily work. They are the new minimum standards that should be covered as part of induction training for new care workers. The provider told us all staff were signed up to specialist health and social care qualifications when their employment starts. They explained the health and social care qualifications covered the same areas in more depth.

People were supported by staff who received regular informal support and no formal supervision. Supervisions are an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. The provider explained due to the length of service of most staff and their open door approach any concerns were managed at the time they occurred. Staff told us they felt supported.

People told us, and we saw, they liked the food offered. Some people told us the "Food is nice", "Food is quite good" and "Alright" when asked about the meals. One person told us the "Food is not very good". A member of staff explained this person had special food because of their medical needs. Seasoning pots were provided to help make the food taste better; we saw these being offered on the dinner table for this person. One relative said, "My relative eats and drinks really well, they haven't lost any weight since moving here [meaning the home]".

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Staff told us they had received training in relation to specialist diets. One member of staff said they, "Had training in food hygiene and training about diets". Care plans showed speech and language therapists and dieticians were contacted promptly when required. When people had complex nutritional needs care plans were detailed and provided clear guidance to staff. For example, one person had been identified a high risk of choking. Their plan detailed ways to reduce the likelihood of choking such as the texture of their food and fluid; this was seen being given during the inspection.

At lunch time we saw people were able to choose where they ate their meal. One person wanted to eat in the lounge rather than the dining room. This choice was supported by the provider and staff. Others chose to eat in their bedrooms. Appropriate support was provided for people who required it. When people wanted extra food they told us they could ask. One person said, "We can ask for extra". Other people told us they "Get a choice of two foods" and they could "Get drinks whenever I want".

A second person was at high risk of falls. To alert staff when they got up they had a piece of equipment which sounded an alarm. We saw this being used on their arm chair during the inspection. One member of staff confirmed the person did not have capacity to consent to the use of this equipment. There was no MCA assessment or a best interest decision in place for the use of this equipment. We spoke with the provider who said the person had arrived at the home already using the equipment. The only MCA assessment in their care plan said, "To find out if [person's name] has mental capacity and can make decisions". It was not in relation to a specific decision in line with the principles of the MCA. This meant the MCA code of practice was not being followed for this person. Following the inspection the provider informed us the person's relative had the correct power to make the decision on their behalf.

Good

# Is the service caring?

## Our findings

People and visitors told us staff were kind and caring. People said, "The staff are very, very nice", "The staff are kind and caring" and "Very nice girls". Visitors said, "All of the staff are very approachable, including the management team" and "The staff speak to my relative so kindly". We saw lots of positive interactions between staff and people. For example, a person was asked by a member of staff if they had seen a hairdresser. Another member of staff told us they "Make a point of saying good morning" to everyone even if they are not directly working with them.

People's privacy was respected and all intimate care was provided in private. Staff knew they should shut the door and close curtains when supporting a person. A member of staff said they "Keep reassuring [them]" during intimate care. A person wearing a skirt whilst being hoisted had their legs covered with a blanket. Staff knocked on people's bedroom doors and waited for an invitation before entering. One person said, "Staff always knock on the door".

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. Staff tried to involve the person if they were in the room when we had a conversation. The provider and registered manager closed doors before having confidential conversations with people and their relatives.

We saw people were able to have visitors at any time throughout the day. As visitors came through the front door a bell sounded so staff knew to come and greet someone. Every visitor was asked to sign the visitor's book when they arrived and sign out when they left. This meant people were able to have visitors but were kept safe by staff. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. During the inspection we saw visitors in bedrooms and communal lounges.

People made choices about where they wished to spend their time. For example, some people preferred not to socialise in the lounge areas and spent time in their bedrooms. People told us "People take time to listen to what I am saying" and "Can choose when to go to bed and get up". Others spend time in communal areas but were able to make themselves drinks in a nearby kitchenette. We saw a person asked if they wanted to go to their bedroom; the person clearly indicated they did not want to and this was respected.

People's cultural and religious needs had been considered. These were identified in their care plans and through conversations had with them. For example, one person's care plan identified their religion and how they would like to be an active member of the church. It said, "[Person's name] is a member of the Methodist church, [they] like to go to services on a Sunday". Staff confirmed they took the person to church. Another person was younger and enjoyed visiting exotic dancers whilst on their holidays. The staff supported them to carry out these wishes. Other people told us they did not follow a religion and they did not have specific cultural needs; this was respected by staff.

People had individualised end of life care to meet their preferences and provide dignified care. The

registered manager and provider made sure anyone nearing the end of their life had someone with them. If the person's family were at the home they made arrangements so they could stay overnight. The PIR told us the provider and staff had links with the local hospice. During the inspection the local hospice team arrived to support someone at the end of their life. Their relatives were given support and advice from the registered manager and provider. Both had additional qualifications which provided them with counselling skills required to support the relatives.

Good

# Is the service responsive?

## Our findings

People were able to take part in a range of activities according to their interests. One person told us they like to "Play on the computer. Like to keep mind awake". They continued to tell us they had been on regular holidays supported by their choice of staff. Other people participated in a music and movement group and a cooking session. Visitors said, "There are lots of musical activities which my relative enjoys. They made Christmas decorations last week and another time they had all helped to make banana cake. My relative does more here than at home" and "There are different entertainers that come in and therapists".

The PIR told us and we saw the provider had recently employed an activity coordinator. The activity coordinator told us they had "Been welcomed" and "Can buy what I need". People were being asked what activities they would like and feedback forms were completed. These informed the activity coordinator the types of activities to increase. For example, there were regular cooking sessions and gardening sessions. Before any activity began staff would ask people if they would like to be involved. In addition to these sessions, there were regular activities including a singer, a hair dresser, music and movement and aromatherapy.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. This reflected what was said in the PIR. For example, people assessed at risk of pressure sores had care plans with details of preventative measures such as regular position changes. Associated documentation showed that people had been frequently repositioned in accordance with their care plan. One person requiring this said, "They [the staff] come and turn me regularly so I don't get sore". This meant the staff were familiar with guidelines in their care plan. There were occasions when gaps were present which prevented information being shared about how wounds had been treated and people's preferences in relation to this. This meant it was not clear whether people had chosen their treatment and how the wound had healed. We spoke with the registered manager who understood and told us they would change the way wound care was recorded.

Other people had care plans highlighting their wishes, likes and dislikes. For example, one person had a detailed care plan specific to their age and gender. There were instructions to staff such as "Dress in comfortable, contemporary night shirts – t-shirt style" and "Book hair dresser every four to six weeks for a trim". The plan contained details of weekly aromatherapy sessions which were funded by the provider. Another person was unable to verbally communicate with staff. Their care plan contained information to tell staff how to assess their feelings based on facial expressions. By care plans having these details staff were able to provide personalised care and support for people.

The staff responded to changes in people's needs. People and relatives told us they had been involved in reviews; the records demonstrated this. For example, one person had mobility which was reducing. They enjoyed smoking but were unable to go outside for their cigar. The provider and staff had created way they could use an electronic cigar without using their hands. The person smiled when we asked them about whether their changing needs had been met. Regular updates had been recorded in the person's care plan providing more information for staff. By responding to changes people were receiving appropriate support

from staff.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. Each care plan showed there had been involvement of the person and others important to them such as family members and health and social care professionals in the assessment process. By involving people and others close to them in their pre-admission assessment it meant people's needs could be understood, care needs met and necessary risk assessments put in place. It also meant for those who had difficulty communicating their wishes, preferences and needs were understood and met by staff.

The registered manager and provider sought people's feedback and took action to address issues raised. There were regular resident surveys to allow people to express their opinions. The provider told us they had an open door policy so people, staff, other professionals and relatives could raise concerns and they could be resolved immediately. For example, a person was upset because they had to wait for support in the evening to go to bed. In response, the provider and registered manager met with the person and their relatives the next day. A solution was found which meant the person knew what time they would receive evening support in the future. The person and their relative told us they were happy with this solution.

There were many compliments received by the home. This included a selection of cards and letters. Relatives had thanked the home for looking after a family member. For example, "Thank you for providing such a safe, secure and comfortable environment. It was comforting to all around her to be reassured in the knowledge that she was so well looked after" and "We would like to thank you for all the care and attention you provided which was of such a high standard that she always referred to Lyndhurst Park as home. Because of this we all felt comfortable leaving her in your capable hands". The PIR told us and we saw further compliments had been left on a care home website. For example, "Both the management and staff are very caring and approachable, should you have any worries nothing is too much trouble. It's a very relaxed atmosphere and I almost feel like part of the family" and "My mother and I are overwhelmed by the great kindness shown to us all. I have never before met such a group of loving, caring people".

Each person received a copy of the complaints procedure and it was displayed around the home. All the people we spoke with knew how to complain and explained they had never needed to. One person told us they would "Go and see [provider's name]" if they needed to complain. Other people said, "I had one minor concern, but the [registered] manager added something to the care plan and it was sorted" and "I've never had to complain, but I would just speak to the [registered] manager". We spoke with the provider who was proud there had not been a formal complaint for well over 10 years. They explained this was down to their open door policy so people, relatives and staff were not afraid to raise any concerns informally. By managing concerns as they occurred, it prevented them from becoming formal complaints.

Requires Improvement

# Is the service well-led?

## Our findings

The provider and registered manager monitored care and planned on-going improvements using an informal approach. They explained the management were hands on at the home so thought they were able to identify concerns and rectify them. There were few records to show how they audited things, then reviewed patterns and learnt from errors. However, the systems in place to monitor safety and quality of care had not identified all concerns found on the inspection. For example, the systems had failed to be effective in identifying issues found around medicines. The provider and registered manager had not identified people's confidential records were being left accessible to unauthorised persons. Care plans were stored in a lockable office in open trollies. There were occasions when the office was found unlocked, with no member of staff present by the inspection team. By not keeping the office door always locked there was a risk unauthorised people could access the care plans.

When required improvements had been identified action had not always been taken to resolve them. For example, the provider had sourced a fire safety and training company to complete a fire safety risk assessment of the building; some recommendations highlighted to the provider following this visit had not been actioned. We spoke with the provider during the inspection who rectified some of these following the inspection. This meant when concerns with safety had been raised to the management they had not always been resolved.

The provider had ensured there were policies and procedures in place to inform staff how they should be working. Most policies and procedures contained a large amount of detail. However, some policies and procedures were not being followed by the provider and some were not in line with current guidance. For example, the staff supervision policy from September 2016 said, "Formal supervision should be occurring every three months". No members of staff had been formally supervised except for an annual appraisal. Additionally, the policy stated part of the supervision was staff practice being observed. By not completing these, the provider and registered manager had not identified poor practice during medicine administration. We spoke with the registered manager who said they would meet with the nurse and begin competency checks. Following the inspection we were sent information to show this had been followed up to monitor medication administration practices.

The provider was not clear in their policies about the difference between whistleblowing and Duty of Candour. Whistleblowing is when a worker reports certain types of wrongdoing and is protected when reporting issues of concern. Whereas Duty of Candour is the responsibilities of providers to be open and transparent with people when things go wrong with their care and treatment. The provider's Duty of Candour policy said, "This used to known as 'whistle-blowing', but now referred to as a Duty of Candour" which was not correct. By not having a clear understanding there was a risk staff would not understand their duties in relation to whistleblowing and the provider lacked knowledge about their responsibilities in relation to the Duty of Candour. We spoke with the provider who told us they thought all staff were clear of the difference. Staff we spoke with demonstrated an understanding of whistleblowing. They had some understanding of the Duty of Candour and their responsibilities. Following the inspection the provider shared further information from February 2015 about training they had delivered to staff about the

difference between Duty of Candour and whistleblowing.

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

The provider had notified the Care Quality Commission (CQC) of some significant events which had occurred in line with their legal responsibilities. For example, when people had passed away the correct notifications had been sent. This meant they had notified CQC in relation to their statutory obligations.

People, visitors and staff spoke highly about the provider and the registered manager. One person told us, "They [meaning the provider and registered manager] come to see you". Others smiled when we spoke about them. We saw the provider and registered manager greeting people and knew their needs and wishes. For example, one person was calling out for the provider who went to see them. When the provider returned they explained this was their routine every morning. Staff said, "I enjoy working here. We have a good team and the management are approachable" and "The manager is very approachable and communication is good".

During the inspection when issues were found the provider and registered manager were prompt in responding to them. For example, when decisions had not followed the principles of the MCA the registered manager arranged best interest meetings. Guidance had been created for topical creams because staff were administering them with no written instructions. This meant the provider and registered manager demonstrated they wanted to make sure people were kept safe and their care needs met.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The provider and registered manager were supported by nurses and senior care staff. One member of staff said, "Support is from the top right down". The provider told us they were currently increasing the responsibility for senior carers. This was so they were more actively involved in writing the care plans and taking on key roles supporting people daily. It also meant they were supporting the nurse to lead each shift. By doing this the provider hoped it would reduce the workload of the nurses.

The provider and registered manager had a clear vision for the home which was to make it feel like the people's home and an extended family. They wanted an open culture where everyone felt involved and could make suggestions for improvement. Their vision and values were communicated to staff through monthly staff meetings. Staff told us "I'm listened to. If I go to management with a problem, they will always help. We ask and we get" and "They will act if it is feasible". Another member of staff gave us an example of a problem with a hoist which was replaced by the provider promptly.

The registered manager was a registered nurse and the provider had previously been a social worker. The PIR said, and they told us, their skills and knowledge were kept up to date by on-going training and reading including health and social care journals. The provider was a Regional Chair of the Registered Nursing Home Association which gave them access to a range of resources such as seminars and training.

The PIR told us and we saw the home had been awarded the number one nursing home in the South West and was the seventh in the UK on a national care home website. This was for the period from 2015 to 2016 and the accolade was repeated for the period 2016 to 2017.The provider told us this was a reflection on their low staff turnover and high quality care they delivered. They had obtained a "Certificate of Excellence" from a local college for their continued support of learners in health and social care. During the inspection we saw a student being supported by members of staff on a placement whilst completing their health and social care qualification. This meant the provider was setting themselves high standards to keep up the quality of

care.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance. This is a breach of Regulation 17 (1) (2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |