Care South

Sussexdown

Inspection report

Washington Road
Storrington
West Sussex
RH20 4DA

Tel: 01903744221
Website: www.care-south.co.uk

Date of inspection visit:
17 May 2018

Date of publication:
13 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Sussexdown on 17 May 2018 and the inspection was unannounced. Sussexdown is a 'care home' providing accommodation, nursing and personal care and is registered for 77 people. People in care homes receive accommodation and nursing or 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.

On the day of the inspection there were 75 people living at the home. The home is divided into three units; the Princess Alexandra unit can accommodate up to 20 people living with dementia, the Princess Alice unit can accommodate up to 34 people with residential care needs and the Douglas Bader unit provides nursing care for up to 23 people. The home caters for people with a range of needs including nursing, physical disability, dementia or mental health conditions. The home is surrounded by large landscaped gardens which was accessible for all people living at the home.

Our observations and feedback received about the care provided at the home demonstrated that people's experience was variable, depending on which unit of the home people lived in.

The provider had a range of systems and processes in place which aimed to ensure good governance, however they were not consistently effective in identifying shortfalls in practice and the inconsistency in the quality of care people received across the home. For example, there was inconsistency in the person-centred approach people received, inconsistency in the embedding of the provider's values in staff practice and inconsistent access to meaningful activity, depending on which area of the home people lived in. Records were not consistently completed which did not give assurance that people received the support they required in a timely manner.

There was an inconsistent approach in ensuring relevant people were included in making best interest decisions. For example, one person's mental capacity assessment said their mother should be involved in all decisions about their care. However, there was no evidence that their mother had oversight of these decisions.

People did not consistently have their needs met in a person-centred way. Feedback and observations of people's experiences were variable depending on which unit of the home people were living in. In the nursing unit, staff were task focussed and did not spend time to engage and chat with people.

People's care plans did not consistently consider all their needs. Some care plans lacked information about the person, their likes and dislikes. This meant that some people may not have received care in line with their preferences. People's access to meaningful activities was inconsistent depending on which unit of the home they lived in. There was a lack of vibrancy in the nursing unit and people were left for long periods of time with little interaction. One person said "I don't do many activities. I can't get there on my own. Sometimes they take me down, sometimes not." People living in other areas of the home had access to

meaningful activities which were driven by people's interests.

People and their relatives did not consistently feel involved in discussions about their care. On the nursing unit of the home, one relative told us, "I come in everyday so my mum's care should be a three-way process." People's care plans demonstrated variable evidence that people, or where appropriate, their relatives had been involved in the review of their care.

We have made a recommendation about involving people's relatives, where appropriate, in decisions about their care.

People said they felt safe living at the home. One person told us, "I am very well looked after and feel very safe." Another person told us, "Staff are very good to you and kind. I feel safe here and there are a sufficient number of staff." Staff were knowledgeable about safeguarding and had received relevant training. The provider had robust recruitment procedures in place which ensured people were safe to work prior to them starting. Risks were well managed to ensure people were safe. People had access to medicines when needed and these were administered by trained and competent staff. The management, administration, storage and disposal of medicines was safe.

People spoke highly of the food, one person told us, "The food is very good and the cook will always cook something different if I don't like what is on offer." People who required specialist diets had their needs met appropriately. People's needs in relation to hydration were met.

People were supported by staff with the appropriate skills and knowledge to do so. Staff had a good understanding of capacity and consent. Staff were suitably trained to care for people's needs and were knowledgeable in their approach. People received access to health care in a timely manner and staff recognised changes in people's needs in a timely way. For example, one person living with diabetes had good access to a multi-disciplinary team to support their needs, which included GP, chiropodist, district nurses and opticians.

We observed positive and respectful interaction between staff and people across the dementia and residential areas of the home and people were treated with kindness and respect on these units. One person said, "Staff are exceptionally kind, they respect my views."

People and relatives were consistently involved in their care, in the units for people living with dementia and residential needs. For example, one care plan for a person living in the residential area of the home had extensive detail about their life history completed by their husband. This then informed the care they received.

People's right to privacy was respected. Staff were observed asking for consent, and knocking before entering people's rooms. People's cultural and religious needs were met, there was an on-site chapel. This was open at any time for people to use and a priest delivered a monthly service for people of all faiths.

Concerns and complaints were responded to in a timely manner. People had access to the complaints policy and complaints received were responded to in a timely manner. One person said, "I am not afraid to let staff know if I am unhappy but I have not needed to."

People were supported in a comfortable and dignified manner at the end of their life. Staff spoke compassionately about end of life care and had a good understanding of how to support people and their families.

At the time of inspection there was no registered manager in post. The previous registered manager had left on 8 May 2018. 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. The provider had ensured interim management support was in place. People and staff spoke highly of their management. A member of staff said "they are so approachable, whenever I go to them I know they will listen. They are present, come over to the unit regularly and they are always happy to help."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe and staff were knowledgeable about safeguarding and recognising signs of abuse.

Risk assessments were robust and included actions taken to reduce risk of harm for people whilst maintaining their independence.

Safe systems were in place to manage, administer, store and dispose of medicines. People had access to medicines as and when they needed them.

There were enough suitable staff to care for people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The approach to involving relevant people in the best interest decision making process was inconsistent and unclear.

People spoke highly of the food and people had their needs met if they required a specialist diet.

People were supported by staff with the appropriate skills and knowledge to do so. Staff had a good understanding of capacity and consent.

People's needs were assessed holistically and people received support to access health care services in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported in a dignified or respectful way depending on which unit of the home they lived in.

People and relatives were not consistently involved in their care, people's experience of this was variable depending on which unit

of the home they lived in.

People's right to privacy was respected. Staff asked consent before entering people's rooms and supporting them.

People's cultural and religious needs were met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive person-centred care that was reflective of their needs and preferences.

People's access to meaningful activities was inconsistent depending on which unit of the home they lived in.

Concerns and complaints were responded to in a timely manner.

People were supported in a comfortable and dignified manner at the end of their life

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's values were not consistently embedded into staff practice at the home.

Systems and processes were not consistently effective in identifying shortfalls in practice and the inconsistency in the quality of care people received across the home.

People, their relatives and staff were complimentary of the current management and leadership of the home.

Staff understood their roles and responsibilities and felt supported by the management team. There was no registered management at the time of inspection. However, the provider had ensured interim arrangements were in place.

Staff worked well with other health care professionals to ensure people's needs were met.

Sussexdown

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 was a comprehensive inspection which took place on 17 May 2018 and was unannounced.

The inspection team included two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Both experts by experience had expertise around older people and dementia care.

We spoke with the interim manager, an operations manager, nine members of staff, nine relatives and 17 people who live at the home. We completed observations in communal areas of each unit, pathway tracked the care of eight people and reviewed four records relating to staff recruitment. We also looked at other records including safeguarding, policies and procedures, care plans, risk assessments, accidents and incidents, deprivation of liberty safeguards (DoLS), infection control and medicines.

Before the inspection, we reviewed information relating to the home including correspondence from people, professionals, and notifications sent to us by the registered manager. A notification is information about important events which the provider is required to tell us about by law. We also used information the provider sent to us in the Provider Information Return (PIR). This 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.

At the last inspection on 18 and 22 November 2015 the home was rated good overall. However, on this inspection, the rating had deteriorated to Requires Improvement. The reasons for this are detailed in our findings for each key question.

Good

Is the service safe?

Our findings

People were safe and protected from abuse. One person said, "I am very well looked after and feel very safe." A relative told us, "I know that I can leave my loved one and they are safe and well looked after." Staff had a good understanding of safeguarding procedures and could identify different types of abuse. Staff were confident in how they would manage a potential safeguarding and said they felt able to report concerns. The manager understood their responsibilities in reporting safeguarding and we saw evidence that safeguarding concerns were reported and investigated.

Risks for people were assessed and managed safely. Risk assessments were detailed and identified the hazard and control measures in place to mitigate the risk. For example, one person had epilepsy and was at risk of seizures. Their risk assessment identified that having a high temperature can be a trigger for their seizures. The assessment detailed that the person should have a well-ventilated room and to have a small blanket instead of a duvet to reduce the risk of spikes in their temperature. We observed that staff followed this guidance which ensured the person's risk of seizures was reduced. Environmental risks were assessed and monitored which ensured a safe, well maintained and accessible environment. For example, there was a very large garden to the rear of the home and the provider ensured people could access it safely and when they would like to. People had alarms they could take with them to alert staff if they had a fall or required assistance.

There were sufficient numbers of staff to ensure people remained safe and met their needs. One person told us, "I just have to press my buzzer and someone comes to see what I want" and another person told us, "Staff are always popping in to see if I need anything." The manager used a 'dependency tool' to continuously monitor the number of staff needed across the home. They told us using the tool allowed them to identify the level of need had increased significantly on the nursing unit of the home. The manager reviewed the information obtained from the dependency tool and had requested the recruitment of additional staff to the unit. The operations manager confirmed that this is an area that they were addressing. There were robust recruitment processes in place which included criminal records checks being undertaking with the Disclosure and Barring Service (DBS) as well as ensuring that appropriate references were obtained. This ensured staff were suitable to work in the home prior to starting.

People received their medicines safely in all areas of the home. There were robust processes in place to safely order, store, administer and dispose of medicines. We observed the administration of lunch time medicines. Staff used an electronic medication administration record (EMAR) to support them to administer medication safely. A member of staff said "The EMAR is much better than paper records as it is easier to use and it ensures we do not make mistakes. The paper charts were really difficult to use." We observed EMAR's for six people, these records showed that people receive their medicines in a timely way. If people required medicines on an 'as and when' basis they had access to them. There was clear guidance and protocols in place to support staff to administer medicines safely. Only trained staff administered medicines, a staff member told us they were given good training and could only give medicines when they were assessed as competent to do so.

The home was clean and people were protected from the spread of infection. The home was odour free and well maintained. Staff understood their responsibilities in relation to infection control and received training in this area and all relevant staff had food hygiene training. One relative said "my loved one feels that they are in a hotel and that can't be bad." The provider put preventative measures in place which ensured staff had access to personal protective equipment (PPE) and infection control training.

There were systems and processes in place which enabled lessons to be learned and improvements made if things went wrong. The manager analysed information from the audits to identify themes and trends and drive improvement. For example, a falls register is completed monthly informed by accident and incident forms. The manager then used this information to identify risks for individuals and implement mitigating actions. One person was referred to the falls team and had their care plan updated to reflect their change in need following this work. This ensured the persons needs were met and they remained safe. The manager shared learning from incidents at staff meetings and through handovers so staff were aware of issues which improved safety across the home.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection the home was rated requires improvement in Effective due to supervisions not being formally documented, malnutrition universal screening tools (MUST) were not consistently completed and information about daily activities were not displayed in an accessible format in the unit for people living with dementia. At this inspection we found that improvements had been made in these areas. We observed that, where appropriate, MUST's were being completed and used to monitor people's health. Staff had access to supervisions and this was formally documented, staff told us they felt well supported. Activities were displayed in pictorial format on the unit for people living with dementia and throughout the home. However, we identified the practice around best interest decisions required improvement, therefore Effective remains requires improvement.

There was little evidence that relevant people were involved in the process for making best interest (BI) decisions for people. One person's mental capacity assessment stated that their mother should be involved in the decision-making process. A best interest decision was made about the person needing their care plan reviewed but there was no evidence that their mother was involved in this decision as the form was completed and signed by one nurse. Another person's care plan stated their family had been involved in a best interest decision but the form was only completed by one member of staff, which did not provide an assurance that their relative had oversight of the decision. The manager and operations manager said that this is an area they had already identified as needing improvement and had developed an action plan to do this. The manager said that staff had already begun to review MCA/BI decisions for people living on their unit and this work is ongoing. This is an area of practice that needs to improve.

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). People were asked their consent for day-to-day decisions. We asked staff about consent and about their understanding of the MCA. Staff had good understanding of mental capacity and had undertaken training in this area. They could tell us the implications of the Act and of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting.

Relatives provided mixed feedback in relation to people's hydration needs being met consistently on the nursing unit. However, our observations showed people's needs in relation to hydration were met during the course of the inspection. The provider evidenced that there had been low incidences of urinary tract infections, low risk across the home of malnutrition and low incidence of pressure area concerns for people, with none being documented between April and May 2018.

People's need were holistically assessed however, the information gathered about people at assessment was not always used to inform the care they received. We have discussed this further in the responsive

section of the report. The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into the home. The initial assessment processes in place considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability.

People had access to a balanced diet. Menus were varied and were available on people's tables so they could choose what they wanted to eat at lunchtime rather than having to decide prior to mealtime. We observed the lunchtime experience across the home and there was a relaxed and friendly atmosphere. People were chatting and the dining room was a pleasant environment. People spoke highly of the quality of the food. One person told us, "Lunch is very nice" and another said "I like the food, I might have put on weight since I've been here. I eat in the dining room as it is good and social." If people required specialist diets these were catered for, the chef was made aware of people's dietary requirements and planned meals accordingly. For example, the chef ensured there were specialist products and sugar free products available for people living with diabetes, and made food with products higher in calories for people who required a fortified diet.

Staff asked people's consent before supporting them across all areas of the home. For example, one person was struggling to eat their soup at lunchtime. A member of staff noticed this and said "I can see you are having difficulty, would you like me to help you? We all get shaky hand sometimes." The person was happy for the help and the staff member said, "We will do this as a team".

Staff had the skills and knowledge to support people effectively. We observed staff to know people well across all areas of the home. One person told us, "We're very lucky with the calibre of staff." Staff received induction training prior to working on the floor and staff undertake the 'Care Certificate'. The 'Care Certificate' familiarises staff with an identified set of standards that health and social care professionals adhere to in their daily working life. New staff are also allocated a 'buddy' who introduces them to the home and who they shadow with, and their competency was assessed before working alone. Staff received training in relation to older people, for example moving and handling, safeguarding, infection control and dementia which ensured they had a good understanding of how to support people they were caring for. A member of staff told us, "Care South support training opportunities and developing people. I did my NVQ level 2." The interim manager told us, "For specific training we have links with living well with dementia team, local college, St Barnabus hospice and Macmillan nurse for end of life care." This ensured specialist training was available to improve the quality of care provided for individuals with specialist needs.

People were cared for by staff that were suitably supported within their role. Staff received regular supervision and appraisal. All staff we spoke with said they felt supported, one member of staff said "The interim manager is really good, we can talk to her on a daily basis. I've learnt a lot since I've been here from the nurse and the interim manager."

Staff worked well together and across organisations which ensured people received effective care and support. There was evidence that staff worked well together in their teams. To improve communication across the whole home the manager had introduced 'ten at ten' meetings where the heads of each department get together each morning and provide updates, discuss issues and share best practice. The manager implemented this to improve communication between staff as they had received feedback that there is silo working across the home and little communication between units. Staff spoke of their good links with the local GP and district nursing teams and we observed effective communication between staff and health care professionals documented in individuals care plans.

People were supported to live healthy lives and had good access to healthcare support. People had access

to outside health care professionals as and when they needed them. One person living with diabetes had good access to a multi-disciplinary team to support their needs, which included GP, chiropodist, district nurses and opticians. These appointments were facilitated by the staff to ensure the persons needs were met in a timely manner. Another person developed a leg ulcer and there was clear documentation that this had been effectively managed that included a referral to the GP and hospital. The provider employed a private occupational therapist (OT) who visited the home weekly. This ensured people received individualised moving and handling support, provided guidance for staff and ensured people had access to the equipment they needed to remain as independent as possible.

People's needs were met by the adaptation of the building. The home is a large building with landscaped gardens. People living with a disability could access all areas of the home safely, including the gardens. People living in the dementia unit could freely access an enclosed garden. There was a fully stocked bar open every day before lunch, the bar was decorated traditionally and with crests of different RAF regiments linking the home to its military heritage. The bar was very well attended and people appeared to enjoy this opportunity to socialise.

Requires Improvement

Is the service caring?

Our findings

Positive interactions between staff and people were inconsistent depending on which unit of the home people lived in. On the nursing unit staff were task focussed throughout the inspection. For example, in the morning people were sat in the lounge in a semi-circle around the television. Staff were in the room completing records but did not attempt to sit with people or chat with them. We observed a member of staff supporting people in their rooms. They moved people's beds away from the wall and raised their bed rails without asking, this jolted the person and was not respectful. While we were aware of staff's need to balance priorities, there were times when people's requests were responded to inflexibly that meant people's choices and requests were not always considered in the way they should be. This is discussed further in the responsive section of the report.

People and their relatives did not consistently feel involved in discussions about their care. On the nursing unit of the home, one relative told us, "I come in everyday so my mum's care should be a three-way process." A member of staff told us, when asked about people's involvement in their care plans, that carers write what they have done and the nurses and managers complete the plans. When we reviewed people's, care plans we saw variable evidence that people, or where appropriate, their relatives had been involved in the review of their care.

We recommend that the service seek advice and guidance from a reputable source, about supporting people and their relatives, where appropriate, to express their views and involving them in decisions about their, or their loved ones, care, treatment and support.

Some people had been involved in decisions about their care and relatives had been involved, where appropriate. For example, one care plan for a person living in the residential area of the home had extensive detail about their life history completed by their husband. This then informed the care they received. Staff were aware of the person's life history and became animated when talking about their knowledge of people living at the home.

One person told us, "the staff are caring and lovely. I could not wish for better and another commented, "they are great, they always go the extra mile." A relative told us, "Staff are kind and compassionate. They are an amazing bunch and I have so much respect for what they do." Our observations of people's experiences were mixed depending on where they lived within the home.

We observed positive and respectful interaction with people across the dementia and residential areas of the home and people were treated with kindness. One person told us, "Staff are exceptionally kind, they respect my views." On the unit for people living with dementia, staff provided emotional support when people became distressed. For example, when one person became upset a member of staff sat with them, ensured they were facing the person and provided comfort and reassurance by holding the person's hand.

People had the opportunity to express their views about the home and told us that they felt that they were listened to. For example, staff offered people choices about their day to day activities, residents meetings

were held and surveys completed. One person told us, "There is a forum where residents and relatives can talk and we're asked how improvements can be made. What is talked about is listened to and improved." The person said they reported an issue with cleanliness, which was acted upon, and subsequently improved, with the recruitment of a new head cleaner.

People's cultural and religious needs were met. There was a chapel on site that could be used at any time for people of all faiths. The local priest came in and conducted a service once a month.

People's right to privacy was respected and staff understood the importance of confidentiality. We observed staff knocking and introducing themselves before entering people's rooms and asking for consent before supporting people.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person centred care; feedback and observations were mixed across the home. People's access to meaningful activities was inconsistent and we received mixed feedback from people dependent on which unit they lived in. There was a lack of vibrancy and little meaningful interaction between staff and people on the nursing unit. One person living on the nursing unit told us, "I don't do many activities. I can't get there on my own. Sometimes they take me down, sometimes not." And another said "I haven't been to any activities yet. No one to one activities either." We observed some people being left alone for long periods of time watching the television or being cared for in bed on the nursing unit. Although staff were kind in their approach with people, there was little evidence of activities or 1:1 engagement with people on the nursing unit. This meant some people may be at risk of social isolation as we saw minimal interaction with staff other than as part of task related activity.

People's care plans were not always person centred and did not always consider people's preferences or interests. For example, one person had a detailed plan around their health needs but had no information about them as a person, their likes, dislikes and interests. Life history forms were inconsistently completed across the home, with some being very detailed while others were blank. This inconsistent approach did not ensure that all people living at the home received support in line with their preferences.

One person, living on the nursing unit, was told that they would have to stay in their wheelchair until after lunch as the GP was coming to see them. This person was in their wheelchair for a 2-hour period when they were supported to go to the toilet. The person asked the member of staff when their GP was coming. The staff member informed the person that they didn't have this information and that the person would have to stay in their wheelchair, despite the person requesting to sit in an armchair. We observed no further conversation with the person and no attempt made to meet their request. The person remained in their wheelchair for a further 30 minutes and had fallen asleep, which was against guidance in their mobilising support plan. We observed that the person was still in their wheelchair following another 90 minutes even though they asked to sit in a more comfortable chair 2 hours prior. This mean this person's request and preferences were not met or respected and they were not being supported in a person-centred way.

The provider was not ensuring people consistently received care in a person-centred way, reflective of their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people received person centred care. For example, one care plan had a detailed life history and we observed that their previous profession as a gardener which had been considered when supporting this person to access meaningful activities. The person had recently been on a trip to a garden centre and were involved in gardening at the home. Staff noted a change in one person's memory and identified they had become more forgetful. Staff responded to this change and referred them to the memory assessment team to ensure their needs were met. One person's communication plan identified that they were unable to communicate verbally. The plan provided staff with good guidance on how to support the person with signs which might indicate they were in pain or discomfort. This ensured staff could respond effectively to their

change in needs. Another care plan identified that the person liked listening to music and had a multi coloured light in their room which they enjoyed watching, an activity we observed during the inspection.

In the units for people living with dementia and residential needs, people had good access to activities. There was a wide range of activities available which a member of staff said was directed by the resident's ideas. One relative told us, "There are a good selection of activities and appropriate activities." One person spoke about their love of dogs and how they used to own them. They told us that a member of staff brings their dog in daily so she can walk it. We later observed the person walking the dog around the grounds with a member of staff, and the person looked happy and engaged. The home originally provided care for people with a link to the RAF (Royal Air Force) and the provider has links with the 'Lest We Forget' and 'Not Forgotten' associations who support ex-service men and women. These voluntary bodies support people to access a variety of annual trips and events.

People had access to technology to meet their needs. The provider recognised the importance technology could have on people's access to resources, stimulation and engagement. The provider had invested in electronic tablets that people could use to meet their social needs. People used these to access app-based activities to provide meaningful occupation and entertainment.

People were given information in a way they could understand. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. There was basic signage around the home to help people navigate and identify where they were and activities were displayed in a pictorial format so everyone could see what was going on daily within the home. People had access to a large library containing books in large print and audio books. This ensured that people had access to literature in a way that supported their needs.

People were supported to maintain relationships that were important to them. We observed people and their relatives using the facilities of the home together such as the gardens and the bar. One person told us, "I get to socialise like I would normally with all of my friends." A relative said having the bar means they can come and see their relative in a relaxed environment "we are having a drink together like we used to do and that is priceless." On the nursing unit a person asked if they could have lunch with their spouse who lived on another unit. The nurse arranged for this to happen and they had lunch together.

Concerns and complaints were listened to and used to improve quality of care. People said they felt able to raise concerns. One person told us, "I am not afraid to let staff know if I am unhappy but I have not needed to." A relative told us "I have not had to raise a concern. I feel if something needs doing I tell a member of staff and it is done. I could not ask for more." The provider's complaints policy and procedure was accessible to people. The manager undertook monthly audits of complaints to identify trends and to ensure corrective action had been taken. Complaints were responded to in line with the providers policy and in a timely manner.

People received dignified end of life care that was responsive to their needs. Staff spoke compassionately of how they have supported people and their families during end of life care. Peoples wishes for end of life care had been discussed with them and people's wishes respected if they did not want to discuss this. At this inspection, one person was receiving support with care at the end of their life. Their relative said, in relation to their relatives end of life care "Everything is fine. The staff are kind and caring."

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of systems and processes which aimed to ensure good governance. These systems did identify some areas of practice that required improvement. However, did not consistently identify all shortfalls in practice or the inconsistency in the quality of care people received across the home. For example; inconsistency in the person-centred approach people received, inconsistency in people's access to meaningful activity and inconsistency in how people and their relatives are included in decisions about their care. The quality audit identified areas of recommendation, however there was no supporting action plan to show how the manager was going to action and address these issues to improve the standard of care people received.

Some records were not complete and accurate. For example, some life history forms were incomplete, this meant that some people may not have their social and wellbeing preferences understood. Most best interest decision forms did not included feedback from relevant people and did not evidence that other people were involved in the decision-making process, other than the nurse completing the form. One person's care plan stated they did not like mouth care and gave staff guidance on how to support the person in other ways. However daily records were incomplete and did not show that the person received this care. One person had a feeding tube (PEG) in place to support them with maintaining their nutrition, staff were given guidance and a daily monitoring form to evidence they are keeping this clean. The monitoring form had been inconsistently completed, at one point was not completed for 8 days, there were no signs of ill-health that would indicate that staff were not completing the correct procedures. However, these checks were not always being recorded. This meant that the manager could not be assured that the required checks were undertaken consistently as per the guidance received from the hospital. After the inspection the provider submitted and update on the actions they took to address concerns in relation to the cleaning of feeding tubes.

The provider's vision and values were not consistently embedded across the home. These values were honesty, excellence, approach, respect and teamwork (HEART). Although staff spoke positively about the providers values and could demonstrate these in some areas, people were not consistently supported in a person-centred way, depending on which unit of the home they lived in. This is discussed further in the responsive section of the report. The provider's systems and processes had not ensured their values were embedded and improved all people's experience of living at the home.

The manager reviewed feedback given at the inspection and implemented actions to address areas for improvement. However, whilst they took swift action, their systems had not identified the inconsistent approach and people's variable experiences across the home prior to the inspection.

The provider's systems and process were ineffective in identifying the inconsistency in care people received across the home, and not all records were accurate and complete. This is a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At the time of inspection there was no registered manager in post. The previous registered manager had left

their post on 8 May 2018. 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. The provider had ensured management support was in place. There was an interim manager who had stepped up from their deputy manager role and they were supported by an operations manager. The manager had worked at the home for 6 years and knew people and staff well, they had been in their current post for 2 weeks prior to the inspection. The interim manager has since been made permanent in the role and has applied for registration with the Care Quality Commission.

People and staff spoke very highly of the manager and team leaders. One member of staff said, "The manager is very good, things run smoothly." Another said of the manager "they are so approachable, whenever I go to them I know they will listen. They are present, come over to the unit regularly and they are always happy to help." A relative wrote the manager, following the passing of their mother and said, 'She was always treated with the upmost patience, kindness and dignity. I am sure this was in no small part due to your guidance and supervision.' The manager understood the role and regulatory responsibilities of a registered manager and was undertaking these tasks effectively. They had a proactive approach to managing the home and had already begun to make changes to drive improvement. For example, improved communication across the home to reduce the perception teams across them hone not working together.

We saw examples of where specific audits improved the quality of care people received. For example, health and safety audits were undertaken quarterly, one identified that some staff were due first aid training. A request was immediately sent to head office and staff were trained in a timely manner. The manager undertook a range of audits such as medicines, accidents and incidents and safeguarding to monitor and improve the quality of care. Actions were taken when there was a noted issue. For example, there was an incident when medicine stock was not available for a person, immediate action was taken to ensure the medicine was delivered in a timely way. The audit of this incident allowed the manager to assess what had happened and put mitigating action in place to reduce the likelihood of this occurring again which included contact with the pharmacist to agree future delivery times. The manager had plans to streamline auditing to further drive improvements in the quality of care people received.

People, relatives and staff were engaged in the running of the home. For example, the provider ensured there were annual surveys for people and staff to complete, analysis of the responses was then used to drive improvement at the home. There were residents and staff meetings at the home and people said they felt comfortable in communicating any concerns. The manager had improved communication further and planned to do this by having daily meetings with the leads from all areas of the home, more structured resident's meetings and further involving people and staff in decision making at the home.

Staff work in partnership with other organisations to ensure people's needs are met. We observed positive interactions between staff and visitors. Staff kept people informed of health-related appointments and ensured they were supported to attend them, where necessary.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring people consistently received care in a person-centred way, reflective of their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always effective in monitoring and improving the quality of care people received.