Croftwood Care UK Limited

Westhaven Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 September 2018 and was unannounced.

Westhaven is a 'care home'. 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. Westhaven is registered to support up to 52 people. At the time of the inspection, there were 45 people living in the home.

This is the first comprehensive inspection since changes were made to the providers registration, therefore there is no previous rating.

A registered manager was in post. 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. Feedback regarding the management of the service was positive.

We looked at how risk was managed and found that it was not always assessed and managed safely. Personal emergency evacuation plans did not provide sufficient information to ensure people could be safely evacuated in the event of an emergency and staff had not received training in how to use the evacuation equipment.

Medicines were stored safely and protocols were in place for medicine prescribed as and when required. However, sufficient information had not been recorded to ensure medicines administered covertly (hidden in food or drink), were administered safely.

Information regarding applications to deprive people of their liberty was not robustly recorded and it was not always clear whether an application had been made, or an authorisation was in place. However, we found that appropriate applications had been made.

People's consent was sought regarding their care and treatment. However, mental capacity assessments completed were not always in line with the principles of the Mental Capacity Act 2005. We made a recommendation regarding this in the main body of the report.

Care plans were not always in place to guide staff how to meet all of people's identified needs. However, the care plans we viewed were detailed and reflected the preferences of the person to enable staff to get to know them as an individual.

People felt safe living in Westhaven and staff were knowledgeable about safeguarding and how to raise concerns.

Records showed that appropriate recruitment checks had been completed to ensure staff were suitable to work with vulnerable people. Some people told us there were not always enough staff on duty, especially at weekends. Since the inspection the registered manager has told us an extra member of staff is now on duty each weekend.

People were supported by staff and external health professionals to maintain their health and wellbeing.

Staff were supported through induction and supervisions, although some staff felt they would benefit from more regular supervisions. Training was provided to help ensure staff had the knowledge and skills to meet people's needs.

People told us they enjoyed the meals available and that they always had a choice.

Staff were kind, treated people with respect and protected their dignity and privacy. People were encouraged to be as independent as they could be.

People felt able to speak to staff and raise concerns when needed. They were confident they would be listened to. Friends and family could visit at any time and were always made welcome by staff.

People had choice in how they spent their day and were supported and encouraged to make their own decisions. A range of activities were available both within the home and in the local community.

A system was in place to manage complaints appropriately.

Systems in place to monitor the quality and safety of the service were not effective. Audits did not identify all of the concerns we highlighted during the inspection and actions identified through the audits, had not all been addressed.

Systems were in place to gather feedback from people regarding the service.

You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not always safe.

Risk was not always assessed and managed safely.

Sufficient information had not been recorded to ensure medicines administered covertly (hidden in food or drink), were administered safely.

People felt safe living in Westhaven and staff were knowledgeable about safeguarding and how to raise concerns.

Records showed that appropriate recruitment checks had been completed to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Applications had been made appropriately to deprive people of their liberty, however records were not always clear.

People's consent was sought regarding their care and treatment. However, mental capacity assessments completed were not always in line with the principles of the Mental Capacity Act 2005.

People were supported by staff and external health professionals to maintain their health and wellbeing.

People told us they enjoyed the meals available and that they always had a choice.

Is the service caring?

Good

The service was caring.

Staff were kind, treated people with respect and protected their dignity and privacy. People were encouraged to be as independent as they could be.

People felt able to speak to staff and raise concerns when needed. They were confident they would be listened to.

Friends and family could visit at any time and were always made welcome by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Plans were not always in place to guide staff how to meet all of people's identified needs.

A range of activities were available both within the home and in the local community.

A system was in place to manage complaints appropriately.

People's end of life care wishes had been discussed and recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not effective.

A registered manager was in place and feedback regarding the management of the service was positive.

Systems were in place to gather feedback from people regarding the service.

Westhaven Care 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 10 and 11 September and was unannounced. The inspection team included two adult social care inspectors, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service to gain their views.

We used all of this information to plan how the inspection should be conducted.

A Provider Information Return (PIR) is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We did not ask the provider to complete this prior to the inspection.

During the inspection we spoke with the registered manager, a visiting area manager, six members of the care team, the administrator and the chef. We also spoke with five people living in the home and five visiting relatives.

We looked at the care files of nine people receiving support from the service, five staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

Requires Improvement

Is the service safe?

Our findings

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. Records also showed that systems were in place to monitor and assess the environment to help ensure it is safe. For example, contracts were in place to check the fire alarm and firefighting equipment, gas, electrics and lifting equipment.

However, we found that risk to people was not always assessed and managed safely. For instance, personal emergency evacuation plans (PEEPs) were in place, but they did not advise what support people would need to get down the stairs in the event that they needed to evacuate the home. We discussed this with the registered manager and following the inspection, they provided evidence that the PEEPs had been updated. We also found that emergency evacuation sledges were in place on all stair wells, but no staff had received training in how to use them safely. We discussed this with the manager who told us they thought it had been included in recent fire marshal training, but now realised it had not and they booked training for staff straight away. We also saw that sluice room doors were left open on a number of occasions throughout the inspection. Chemicals that could cause harm to people were inside the sluice and should be stored securely.

Records showed that when people displayed behaviours that could be challenging, there were not always care plans in place to guide staff how best to support the person or identify and avoid potential triggers. This meant that staff may not have access to information on how best to meet people's needs.

This is a breach of Regulation 12 of the Health and Safety Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. Staff told us and records we viewed confirmed, that staff had completed training in relation to the safe management of medicines and had their competency assessed. A policy was also available to guide them in their role.

Medicines were stored in trolleys or fridges in locked clinic rooms. The temperature of the rooms and fridge were recorded regularly; almost daily and were within recommended ranges. If medicines are not stored at the correct temperature, it can affect how they work. Medicine administration records (MARs) had been completed fully and reflected any allergies people had. This reduced the risk of people being administered a medicine they are allergic to. We checked the storage and stock balance of the controlled medicines and they were accurate. Controlled medicines are those that have controls in place under the Misuse of Drugs Act and associated legislation.

We saw evidence of PRN (as required) protocols and records in most people's records who required it. PRN medications are those which are only administered when needed for example for pain relief. This helped to ensure that people received the medicines they needed consistently, when they needed them.

Records showed that people who had their medicines administered covertly (hidden in food or drink), did not always have sufficient information recorded to show that these medicines were administered safely. For instance, it had been agreed that one person required their medicines to be administered covertly. The necessary assessments had been completed to ensure they would be given legally, however there was no information available from the pharmacist to establish how to safely administer each medicine, such as in drinks or crushed. The registered manager told us this information had been available and may have been archived. They requested the pharmacist to provide this guidance and they confirmed after the inspection, that this was now in place and there were no concerns regarding how the medicines had been given.

People living in Westhaven told us they felt safe living there and were happy with the care that they received. Their comments included, "Yes, staff are always around and I can call on them", "Yes, it's all closed and locked up" and "Yes, I feel very settled." Relatives we spoke with agreed that the home was a safe place for their family members to live. Their comments included, "Yes, the staff are always present and I know [name] is safe" and "Yes, there are few obstacles about and the dining room is planned well."

Staff had a good understanding of adult safeguarding and how to raise concerns if necessary, what constitutes abuse and how to report concerns. A policy was in place to prompt staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. We found that appropriate safeguarding referrals had been made.

Staff understood the concept of whistle blowing and told us they would not hesitate to raise concerns. Whistleblowing is where staff are able to raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency and protects people from the risk of harm.

Feedback we received regarding staffing levels in the home was mixed. Most people living in the home told us they felt there were enough staff to support them. One person told us, "Yes, they come quickly" and another person said, "Yes, [there are enough staff], they come but it might take a bit longer if they are busy." Most relatives agreed that there were enough staff, but one relative told us, "At times there is a shortfall especially at break time." Most staff we spoke with did not feel there were always enough staff on duty. Their comments included, "There are less staff at the weekend", "Not enough staff at weekends", "Nowhere near enough staff" and "I enjoy my job but don't enjoy the staffing levels."

We spoke to the registered manager regarding this and they told us that as there were no office staff on duty over the weekends, staff on the ground floor opened the front door to visitors and this could be time consuming. The issue had been raised with them and they told us they were in discussions with the area manager about increasing staffing levels at the weekend. Since the inspection, the registered manager has confirmed that an extra member of staff is now on duty on the ground floor each weekend.

We looked at how staff were recruited within the home and saw evidence that application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. There were also checks made to ensure that when needed, staff maintained up to date registration with relevant regulatory bodies, such as the Nursing and Midwifery Council (NMC).

We looked around the home and found that it was clean and well maintained. There was an infection control policy in place and an audit had been completed in April 2018, in which the home achieved 97.2%. Bathrooms contained liquid hand soap and paper towels in line with infection control guidance and this

helped to reduce the spread of infection. Most staff had completed infection control training as well as food hygiene training and we saw that they used personal protective equipment such as gloves and aprons appropriately throughout the inspection.

Accidents and incidents were reported and recorded within the home and we found that appropriate actions had been taken to help reduce risk and prevent recurrences. For example, records showed that a person had fallen. Since the fall, staff had arranged for the person to be seen by their GP and have their medicines reviewed; they had regular observations completed and their risk assessments had been updated to reflect the increased risk.

All accidents were reviewed by the registered manager and sent electronically to head office. As well as internal monthly audits, head office also monitored accidents for any trends or themes that may indicate actions were required. Relatives told us they were kept informed of any incidents and that they felt that staff managed accidents well.

We saw that a system was also in place to learn from external incidents, such as safety alerts which were displayed on notice boards around the home. Staff we spoke with were aware of these alerts.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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). Records showed that people had been assessed to establish whether a DoLS application was required and six authorisations were in place. The registered manager had recently implemented a new process to assess if a DoLS is required and record date of application, expiry and any conditions. Following the inspection, the registered manager confirmed that all required applications had been submitted appropriately.

Not all staff were aware of who had an authorisation in place and we found that care plans were not in place to inform staff when a DoLS authorisation had been received. The registered manager agreed to ensure care plans were put in place to inform staff of DoLS and what restrictions had been agreed for each person and had already attempted to share this information by including it on staff handover sheets.

Care plans showed that when able, people signed to evidence their consent in areas such as photographs, access to records, involvement in care plans and agreement to have student nurses assisting with their support. Staff we spoke with had a good understanding of the MCA and told us they always asked for people's consent before providing care. People living in the home agreed and told us staff always knocked on their bedroom doors. One person told us staff always asked if they wanted support rather than just providing it.

When people were unable to consent, mental capacity assessments had been completed for specific decisions. We found however, that they had not always been completed robustly or in line with the principles of the MCA. For instance, one person's assessment reflected the decision that needed to be made, was that the person had dementia and needed help from staff. The decision was not clear. The outcome was that the person lacked capacity and a best interest checklist had been completed, but there was no information as to what decision had been made in their best interest. Another person's file reflected that the person had consented to the use of bed rails, however there was no signature on the consent form.

We recommend that the provider reviews and updates its processes to ensure consent is sought and recorded in line with current legislation.

We saw that people's needs were assessed holistically, including their physical, mental and social needs a pre-admission assessment was completed prior to people moving into the home. This ensured their needs

were known and could be met by staff from the day they moved in.

People were supported by staff and a range of other health and social care professionals to maintain their health and wellbeing. Records showed that people received advice, care and treatment from their GP, dietician, optician, dentist, speech and language therapist and community nursing teams and advice provided by them was clearly recorded within the plans of care. People told us staff contacted their doctor quickly for them if they were unwell and that a Practice nurse visited each week if they needed anything. An electronic virtual nurse system had been implemented which enabled staff to access healthcare advice to assist them in meeting people's needs effectively.

We looked to see how staff were supported in their roles and saw that they completed a basic induction when they first started in post and then a comprehensive 12 week induction. The registered manager told us they offered supervisions with staff every three months and records provided after the inspection, showed that most staff had received supervisions this year. However, some staff told us they would benefit from more regular supervision, especially during periods of change. The registered manager also told us that staff had been given appraisal documents to complete their part and meetings would then be scheduled to complete the process. However, there was no evidence that any appraisals had been fully completed. The registered manager told us they would be focusing on the appraisals over the coming months.

We requested to see information regarding staff training, however this had not been kept up to date on the day of the inspection and the registered manager shared this information with us after the inspection. These records showed that most staff had completed training that the provider considered mandatory. This included courses such as safeguarding, health and safety, fire awareness, mental capacity and infection control. Staff also completed additional training relevant to their role and based on the needs of people they supported. These included diabetes management, catheterisation, dementia care, syringe driver management, enteral feeding and wound management. Most staff told us they received sufficient training, although some staff felt they would benefit from additional training such as care planning and DoLS.

People told us they felt staff were knowledgeable and had the right skills to support them. One person told us, "Yes, they are very caring and most keen to increase their skills" and another person explained how staff could always tell when their health condition was about to deteriorate and took appropriate action.

Staff in the home had access to relevant legislation and best practice guidance, in order to enable them to provide the most effective care to people. For instance, any safety alerts were displayed in the home and discussed with staff. Staff had access to best practice guidance such as the National Institute for Health and Care Excellence (NICE) guidelines and care plans contained information regarding people's health conditions. This enabled staff to be aware of and understand people's needs and provide effective support.

We asked people about the meals available in the home. People told us they had plenty to eat and drink and always had a choice. Their comments included, "There is too much but its very good, there is quite a good selection and choice", "It's not bad considering, but I wish they would have some sauces like tartar for fish and ketchup", "It's very good, they are building me up and I've put on weight. They give me hot coffee with cream which is lovely" and "I'm a bit faddy but if I don't want it they'll find me something else."

We saw that juice was available in the lounges for people to help themselves to and hot drinks and biscuits were offered regularly throughout the day. We joined people for lunch in one of the dining rooms and saw that tables were set with tablecloths, fresh flowers and napkins and a menu was displayed on each table.

We spoke with the acting chef who was aware of people's dietary needs and we saw that all staff who

prepared food had access to this information within the kitchen. The acting chef told us they could cater for any specific diet, including allergies, preferences, religious or cultural requirements. They also told us alternatives were always available to people and we saw this during lunch. For instance, one person did not want either of the meals available that day, so scrambled eggs on toast was prepared for them at their request.

Risk assessments were in place in relation to malnutrition and we saw that staff made appropriate referrals to other health professionals if there were concerns regarding a person's intake. Advice from these professionals, such as the dietician, was available within people's care files. Staff also monitored and recorded what people ate and drank if necessary, however we saw that this information was not always reviewed to check if people had had sufficient amounts.

The environment of the home was suitable to meet the needs of people living there. The corridors were wide and well-lit with hand rails for people to use if needed. Bedroom doors contained people's name and their room number to help people identify their rooms. Communal areas had also been fitted with a loop system for people who had hearing impairments. Equipment was also available to enable people's needs to be safely and effectively. This included hoists, wheelchairs, grab rails in the bathrooms and specialist shower chairs and commodes. There was a dining room and lounge on each floor where people could spend time together if they chose to.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. Their comments included, "Yes, they are all lovely", "Yes, very kind and great care", "They bend over backwards, when I came out of hospital everything was organised so well", "It's very good, I think I'm one of the spoilt ones" and "Yes they go out of their way to help, I can find no faults."

Relatives agreed and told us, "All staff go above and beyond", "I'm happy, the staff are lovely with [name]", "It's amazing, I have the greatest admiration for the care staff here", "They are very caring people and were very concerned when [name] went into hospital" and "Every effort is made to be warm and friendly. It's a two-way interaction. We are valued as family as well as the residents."

People told us they felt able to share their views and that they were listened to. One person told us, "Yes, I can talk to [staff] and they would listen." Another person said, "If I have anything to say I say it. They are very good with me." A third person told us, "Yes, I have lots of chats, its pleasant."

Staff told us they protected people's dignity and privacy when providing support by knocking on people's doors and providing personal care in private. Care plans reflected this and reminded staff to use 'do not disturb' signs on doors when supporting people with personal care. We saw that people did not have to wait long to receive support when they required it and people were not rushed, such as when eating their meals. We heard staff speak to people in a respectful and warm manner and care plans used language that promoted people's dignity.

We saw that people's personal information was stored securely to protect their privacy. This meant that only people who needed to see this confidential information could access it.

People living in the home told us that staff supported them to be as independent as they could be. One person said, "I have had several falls so I have to be careful, but staff are very good and encourage me as much as possible." Another person told us, "I try and do as much as I can, but if I need help they are there" and a third person said, "My daughter says she can see a big difference since I came in here. She is very pleased."

Care plans also prompted staff to support people's independence. For instance, one person's personal care plan advised staff to encourage the person to wash as much of themselves as possible and to choose their own clothes each day. People who were at risk of falls had sensor mats to enable staff to be alerted when they got up out of bed so they could provide support. This enabled people to continue being as independent as possible, whilst reducing the risk of injury from falls.

Staff supported people to communicate and have their needs and views heard. We heard staff speak to people in ways which they understood. The registered manager told us they had recently supported a person during a short stay who was deaf and used British sign language to communicate. None of the staff were able to sign at the time and used picture cards to establish the person's needs. However, due to this

three staff have now enrolled on a British sign language course. Staff had also sourced talking books for a person who enjoyed reading but had visual impairment. The registered manager told us documents such as the service user guide can be provided in large print and braille and that large magnifying glass was available for people to use.

People were provided with a service user guide when they moved into the home and one was available in the reception. This included information about what people could expect from the service, the types of service available, information on complaints, fire safety and menus. It also advised people that they would be encouraged to maximise their potential by taking informed risks, making informed decisions and being involved in the planning of their care. This showed that people were given information and explanations regarding the service.

Information was also available regarding local advocacy services and the registered manager told us they would support people to access these services whenever needed. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights.

Friends and relatives visited throughout both days of the inspection and all those we spoke with told us they could visit at any time and were always made welcome. The registered manager told us that there were no restrictions as to when people could visit and this encouraged people to maintain relationships that were important to them and prevent isolation. People living in the home agreed and told us, "Yes, they are made very welcome" and "Yes, anytime. My daughter says, 'It's just like home, so I've no worries when I'm at work'." Relatives told us, "We are always made very welcome", "It's been made very clear to me I can come anytime. It's their home so it's OK" and "Yes we are made to feel welcome, we are valued as family and there is support for us."

Requires Improvement

Is the service responsive?

Our findings

We reviewed care files and found that plans were not always in place regarding all of people's identified needs. For instance, one person's care file reflected that they had a health condition that required regular monitoring by a number of different health professionals. However, there was no plan in place to provide clear information as to what checks were needed or the frequency they required. Another person's file showed they could display behaviours that challenged and there was no plan in place to guide staff how best to support the person during these times. We also found that care plans were not in place to inform staff when people had an authorised deprivation of liberty safeguards in place and what restrictions had been agreed. We raised this with the registered manager who agreed to ensure that plans were in place to meet all of people's identified needs. Following the inspection, the registered manager provided examples of updated care plans which included these needs.

Plans were in place in areas such as health, medication, tissue viability, breathing, nutrition, personal care, communication and work and leisure. These plans were detailed and reflected the person as an individual, including their preferences regarding their care and treatment. A map of life was also available within care files and this included information about people's family, education, work, holidays, preferred activities, meals and drinks, favourite books and television shows. People's daily routines were also included, such as when they liked to get up each day and what time they preferred to go to bed. This helped staff get to know people as individuals and provide care based on their needs and preferences.

People told us they had a choice in how they spent their time in the home, such as when they go to bed, when they have a bath and where they spend their time during the day. People's comments included, "I wake up early but press my buzzer to let [staff] know and I might have porridge in bed", "Yes, I decide what to wear; I put everything out at night on the chair" and "I get up about 8am and [staff] help me back to bed about 10pm, which I like."

It was evident that care plans had been reviewed regularly and people told us they were happy with the support that was in place for them. Relatives told us they had been involved in the care planning process and were kept informed of any changes to their family members plan of care.
Staff told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files.

Technology was in use within the home to help people receive care in a timely way and remain safe, as well as to support social activities. This included call bells, sensor mats, use of the virtual nurse system, sensor lights in bathrooms and tablets to enable people to keep in touch with friends and family electronically.

A range of activities were available to people both in the home and in the local community. On the first day of the inspection several people had gone to the local church for lunch. Later that day the 'Cruise' was setting sail and one of the lounges was full of people and their relatives. The registered manager explained that staff had developed the cruise activity which involved setting sail from Southampton and visiting a different country for ten days. They would then have food from that country, do quizzes with a theme of the

country and activities based on this. People told us they had been involved in the planning of the cruise.

Other activities available included bingo, reminiscence sessions, games, movies on the big screen and singing. Outside entertainers also visited the home regularly, including singers, keyboard players, Irish folk music and a ukulele band. Fundraising activities also take place, such as car boot sales, and sponsored walks. Each year people living in the home choose a charity and raise funds for that charity. Special events such as birthdays were also celebrated and the activity coordinator produced a newsletter called the Weekly Sparkle. This included information on things that happened on that day in years gone by and was used as a talking point with people.

People had access to a complaints procedure and this was displayed within the home. Complaints were also discussed at resident and relative's meetings to ensure people knew how to raise any concerns and to advise people that they were welcomed as a way of ensuring good service. People told us they knew how to raise concerns and would be happy to talk to staff or the matron about any issues they had and their relatives agreed. The registered manager maintained a complaints file which showed that complaints had been investigated and responded to appropriately.

Care plans showed that people had discussed their end of life care wishes with staff and relevant health professionals such as their GP. For example, one person's file included an end of life care plan which indicated they had a 'do not attempt resuscitation' order in place and that they had contributed to this decision making. Preferences regarding where they wanted to spend their last days were also recorded. Some staff had completed training to enable to support people effectively at the end of their lives and other staff were scheduled to complete training in January 2019. A new training scheme called 'One chance to get it right' was also being provided to staff. The registered manager told us they worked closely with the GP's and community nurses to support people during these times and nursing staff had completed additional training to support people, such as syringe driver management.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the provider and registered manager ensured the quality and safety of the service provided. Records showed that audits were completed in areas such as care planning, medication record charts, bedroom safety checks, accidents, infection control, dining room and health and safety. We found however, that audits completed did not identify all of the issues we highlighted during the inspection. For instance, care plan audits did not pick up that plans were not in place to cover all of people's care needs and checks did not identify that the environment was not always safely maintained.

When issues had been identified within the audits, clear actions had not always been recorded. For instance, the medicine recording forms had been checked in August 2018 and had identified a number of missing signatures and that creams had not consistently been signed for when applied. However, there was no action plan to identify what would be done to ensure improvements would be made.

We also found that when actions were identified from audits, they had not all been addressed. For example, the care planning audit for one person's file indicated that several actions needed to be completed to ensure the file was up to date and accurate. There was no evidence to say whether the actions had been addressed, so we reviewed the care file and found that they had not been completed. The fire risk assessment completed by the registered manager in January 2018 showed that personal emergency evacuation plans required more detail and that staff had not received training in the use of emergency evacuation sledges. These actions had still not been addressed at the time of the inspection, however the registered manager has since confirmed that they have been actioned. This showed that the systems in place to monitor the quality and safety of the service were not always effective.

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

The area manager visited regularly and completed their own checks and looked at any complaints, safeguarding referrals, staff training, falls and other information relevant to the running of the service. The registered manager told us they were supported in their role and that the provider ensured they had what they needed to make improvements to the service when needed.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People knew who the registered manager was and told us they could go to them at any time if they needed to talk. Their comments included, "I know her and she knows me, she will always stop for a chat even if she is busy", "The Matron is lovely. They are all loving and sweet" and "Matron is very approachable and has sorted a few things out for me." Relatives agreed and told us, "The manager supported me. I have been to the meetings but can bring anything up anytime and I'm very happy", "The management is outstanding, and the home is the best place I viewed" and "Matron is very approachable. She even joins in the activities when she can."

Staff told us they all worked together as a team and that they could raise any concerns with the

management team. Team meetings took place every few months and records showed that topics discussed were relevant and promoted good practice. Areas discussed included safeguarding, privacy and dignity, falls, staff responsibilities and communication. Policies and procedures were also available to help guide staff in their role and we saw that these were updated regularly.

Systems were also in place to gather feedback from people living in the home and their relatives. This included monthly resident meetings, regular relative meetings and annual quality assurance surveys. Results from surveys had been analysed and we saw that most responses were positive.

The registered manager submitted statutory notifications about most incidents and events that they were required to inform the Commission of. However, we found that CQC had not been made aware of all referrals that had been made to the local safeguarding team for investigation. We discussed this with the registered manager who is now fully aware of all incidents that require a statutory notification to be submitted.

Steps had been taken to develop links with the local community and external agencies such as the local authority and clinical commissioning group. People living in the home went to a local church each month for lunch and discussions had been held with a local nursery with the aim of the children coming to the home to visit and spend time with people.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risk to people was not always assessed and managed safely. Care plans were not always in place regarding some identified needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place to monitor the quality and safety of the service were not effective.