Interhaze Limited

Sebright House 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The service:
Sebright House Care Home is registered to provide nursing care for up to 40 elderly people whose primary care needs stem from dementia. The home has five beds contracted for 'discharge to assess' (D2A). People are placed in the home for six weeks under the D2A scheme and within that period they are either discharged home with a care package or discharged to a more appropriate care setting. There were 28 permanent residents and four D2A people living in the home at the time of our inspection visit.

People's experience of using this service:
•The provider's quality assurance processes had not identified shortfalls in the safety and quality of the service provided.
•Risk assessments were in place to manage risks within people's lives, but there were gaps in the records staff completed to demonstrate how they minimised risks.
•There were risks in the environment, that the provider and manager had not identified or minimised.
•Whilst we were confident people received their medicines as prescribed, some practices around the management of medicines needed to be improved.
•Improvements were needed in making the environment suitable for the needs of people living with dementia, ensuring privacy was maintained and providing a homely place for people to spend their time.
•There were sufficient numbers of nursing and care staff on duty to keep people safe and monitor the communal areas of the home.
•Staff felt well-prepared for their role, because they had training in relevant subjects and spent time observing experienced staff before they worked independently.
• Staff understood their safeguarding responsibilities.
•People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
•People's dietary needs, preferences and nutritional needs were assessed and known by staff.
•People were referred to other professionals to support their healthcare, but this was not always done in a timely way.
•Staff were warm, respectful and responsive towards people. They understood people's concerns and anxieties and were quick to offer reassurance.
•Improvements were needed to ensure people were given opportunities to engage in activities and interests that were meaningful to them.
•The provider had appointed a new manager who was open and honest about the challenges within the service.
•The new manager had identified areas where improvements were needed and was working with other organisations and healthcare professionals to improve outcomes for people.

The registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment

Regulation 17 Regulated Activities Regulations 2014 - Good governance

Rating at last inspection:
Good overall with a rating of requires improvement in 'well-led'. The last report for Sebright House Care Home was published on 17 September 2016.

Why we inspected:
This was a planned inspection based on the rating at the last inspection. The previous 'good' service provided to people had not remained consistent. At this inspection the rating has now changed to Requires Improvement overall.

Enforcement:
Action provider needs to take (refer to end of report).

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Sebright House Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by one inspector, a bank inspector and a specialist advisor. A specialist advisor is a qualified health professional.

Service and service type:
Sebright House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have 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.' A manager had been appointed on 7 January 2019 and was in the process of registering with us.

Notice of inspection:
This inspection was unannounced.

What we did when preparing for and carrying out this inspection:
Before the inspection, the registered provider had 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. The registered provider returned the PIR and we took this into account when we made our judgements in this report. We reviewed other information that we held about the service such as notifications. These are events that happen in the service that the registered provider is required to

tell us about. We considered the last inspection report and information that had been sent to us by other agencies.
We also had contact with commissioners who had a contract in place with the registered provider. The commissioners informed us that due to concerns about the service they had imposed a placement stop on new permanent admissions to the home. The placement stop had been lifted two weeks prior to this inspection visit.

Due to people's needs, nobody could provide us with any information about the care they received or quality of the service provided. Therefore, we used different methods to gather experiences of what it was like to live there. For example, we saw how staff supported people throughout the inspection to help us understand peoples' experiences of living at the home. As part of our observations we also used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with three visiting relatives/friends for their view of the service. We also spoke with the manager, a registered manager from one of the provider's other homes, the provider's operational support manager, a nurse, four care staff, the cook and a visiting healthcare professional.

We looked at specific parts of the care records of five people, 15 people's medication records and we undertook a tour of the premises with the manager. We also looked at records in relation to the management of the home such as quality assurance checks, staff training, accidents and incident information and records of complaints and compliments the provider had received.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires Improvement: People were not always safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
•People's individual risks were assessed on admission and care plans described the actions staff should take and the equipment needed to minimise the identified risks.
•Staff told us they could access people's personal profiles on their hand-held electronic devices, so they knew people's diagnosis, risks and how to support them safely.
•However, there were gaps in the records staff completed to demonstrate how they minimised risks to people's skin. Records did not demonstrate that people received pressure relief in accordance with their care plans and there were considerable gaps in repositioning.
•For example, one person's records dated 5 February 2019 indicated they had a wound that measured 1.5cm x 1.5cm and they needed to be repositioned every two hours. On 5 February 2019 there had been a seven hour gap between repositioning and on 6 February 2019 there had been a six hour gap. By the 8 February 2019 the size of the wound had increased to 4cm x 2cm.
•Another person who was at risk of sore skin should have been supported to reposition themselves every two hours, and to be on their back only for eating and drinking. Records showed the person was frequently left on their back for more than two hours, which increased the risk of sore skin.
•Risks around wound care were not always effectively managed. The quality of photographs of wounds was variable and some were blurred which made it difficult to accurately assess the degree of skin damage. Measurements of wounds were not always recorded which made it difficult to evaluate the effectiveness of wound management plans.
•Risk assessments were not always reviewed following incidents. One person had been assessed as at high risk of falls on 22 January 2019. Since that date the person had fallen five times, but the risk assessment and care plan for risk reduction and prevention measures had not been reviewed or updated.
•Staff did not always use safe moving and handling techniques. For example, when two staff supported a person to move from an armchair to a wheelchair, they did not put the brakes on to keep the wheelchair still when the person sat in it.
•We identified risks in the environment, that the provider and manager had not identified or minimised. In one person's en-suite the radiator next to the toilet was extremely hot to touch. The radiator did not have a protective cover which placed people at risk of burning their skin. In another bedroom, we found some loose, trailing wires. People's wardrobes were not all attached firmly to the wall, which meant there was a risk of people pulling them over. In one bedroom, the rope holding the sash window up was broken and in another there was exposed wiring leading into the sensor alarm. All these issues posed a risk to people's health and wellbeing. The manager brought these issues to the attention of the maintenance person and assured us they would be addressed immediately.
•Many of the bedroom doors did not have catches to keep them shut, which meant they could be easily opened by leaning on them which presented as a falls risk. There was also a risk that bedroom doors would

not effectively hold back smoke in the event of a fire.
•The local Fire Protection Team had inspected the service on 14 January 2019. They had identified several areas the provider needed to address to ensure compliance with the Regulatory Reform (Fire Safety) Order 2005. The manager gave us an action plan they had implemented to address these concerns in order of priority. However, there were no dates to indicate when the work needed to be completed. Following the inspection, the manager confirmed it was anticipated all work would be completed by the end of March 2019.
•Each person had a personal emergency evacuation plan (PEEP) which reflected the support they would need to evacuate the premises. However, records did not evidence that these were completed in a timely manner when people moved to the home. One person had moved to the home in November 2018, but their PEEP was not completed until 26 January 2019.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
•The provider used an electronic system for the management and administration of medicines for people who lived permanently in the home. The system supported safe practice in medicine administration because it alerted staff when medicines had not been given and ensured that safe time periods between the administration of doses was observed.
•Staff who gave medicines had been trained and deemed competent to do so safely. We observed a member of staff giving people their medicines in the morning. They followed good medicines administration practice to ensure people had taken their medicines.
•Overall, documents to support the administration of 'as and when' and covert medicines were detailed enough to ensure these medicines were given safely and consistently. A couple of discrepancies were identified in the records which the nurse assured us they would address.
•Whilst we were confident people received their medicines as prescribed, we found some practices around the management of medicines needed to be improved.
•The storage of medicines was not always safe. Most medicines should be stored below 25 degrees centigrade to maintain their efficacy. The temperature in the medicines room regularly exceeded that and on the day of our visit was 28.3 degrees. The nurse assured us this had been reported to the maintenance person who was due to check the air conditioning unit was working properly.
•Prescribed topical creams were stored in people's rooms, but were not locked away. We were told some of those people could display behaviours which limited what items they could have in their bedrooms. However, they had free access to their topical medicines and the risks of this had not been assessed. Records and stock levels did not evidence that these medicines were always being applied as prescribed. Following the inspection, the manager confirmed action had been taken to ensure the safe storage of such medicines and the application would in future be recorded on the electronic system.
•People receiving medicines in a patch, had their patch applied at the required intervals, but there were no charts to record the application site and removal of patches. Charts provide a safeguard to ensure the application sites are rotated to prevent people's skin becoming irritated or that medicines are absorbed at an unsafe rate. Daily checks were not always completed to ensure the patch medicines remained in place.
•Handwritten medicines records were maintained for people on 'discharge to assess' beds. Handwritten amendments to the records had not been countersigned by a second member of staff in accordance with NICE guidelines to confirm their accuracy.

Preventing and controlling infection
•Staff had received training in infection control and maintaining good hygiene. Staff used personal protective equipment appropriately to minimise the risks of infections spreading.

•However, some areas of the home were not clean, especially the communal and individual bathrooms and toilets. In two communal bathrooms on the ground floor we saw stains and fluids on the toilet raiser seats and there was staining on the floor around the toilet.
•On the environmental tour of the home, a transfer chair was found to be damaged on the arms and a crash mat in a person's room was soiled and damaged. This meant these items could not be cleaned effectively and that put people at unnecessary risk.

Systems and processes to safeguard people from the risk of abuse
•Staff told us they had training in safeguarding people from the risks of harm or abuse. They assured us they would not hesitate to report any concerns as they knew it was their responsibility to keep people safe.
•Staff had no concerns about the work practices of other staff, but told us if they did, they would share them with the manager. One staff member told us if the provider failed to take action to safeguard people, "I would have to whistle blow outside the home."

Staffing and recruitment:
•There were enough staff on duty to keep people safe. A visitor commented, "I always think there are plenty of staff, everywhere you look there seems to be staff."
•Staff confirmed staffing levels enabled them to provide safe, effective care.
•Staff told us the deployment of staff ensured there was always a staff presence in communal areas. This meant they could monitor people's behaviours to identify any risks and provide appropriate support to keep people safe.
•Staff were responsive to people's needs for assistance. Where two staff were needed to support a person to mobilise, the person only waited three minutes for a second member of staff to come and support them.
•Staff told us the provider checked with the DBS and previous employers, to make sure they were suitable for their role, before they began working for the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Adapting service, design, decoration to meet people's needs
•Improvements were required in making the premises suitable to meet the needs of people who lived with dementia.
•NICE guidance states providers should ensure environments are enabling and aid orientation and include attention to lighting, signage and garden design and people should have access to a safe external area. Most people's bedroom doors had their name and photo on them. However, there were no directional signs to help people find their own bedrooms across the three floors. Not all the bathrooms and toilets had picture signs on them which could have supported people to access them independently.
•The home had a secure internal courtyard, but the slabs were uneven and a potential trip hazard.
•At the time of our inspection, the provider was refurbishing the home, but some communal rooms which were seemingly finished were not 'homely' or inviting or had any artefacts or items of interest to people who were living with dementia.
•In the dining room there were some books, pieces of china and large teddies, but in the front lounge, where seven or eight people spent most of the day, there was nothing to capture people's interest. The furniture in the front lounge was not arranged to be 'homely' or inviting. All the chairs were arranged around the walls and the room was a corridor between the dining room and some of the bedrooms. There was a large television screen attached high up on the wall and four armchairs were against the wall under the screen. During the time we spent in this room, only one person looked at the television screen, and they were sat at the side of the room, with people and staff constantly walking between them and the television.

Assessing people's needs and choices
•Before people moved to Sebright House, a comprehensive assessment of their needs was completed. People's assessed needs were documented in their care plans.
•A visiting health professional told us, for people in the 'discharge to assess' beds, the multi-disciplinary team assessed people's risks, before people moved to the home, to make sure the provider could manage people's risks safely.

Supporting people to eat and drink enough with choice in a balanced diet
•People were asked about their dietary needs, preferences and any allergies during their initial assessment, before they moved into the home.
•Where people had specific likes and dislikes, allergies and other dietary requirements, these were recorded in their care plan and on lists in the dining room and kitchen. A relative told us their relation was always offered the pureed diet they needed, but said the pureed meal was often 'too runny' and not appetising to look at.

•At lunchtime, people were offered a choice of different meals, and those who required it were assisted by staff sitting quietly beside them. People were supported to eat at their own pace, by staff who spoke encouragingly to them.
•Lunchtime was relaxed, not rushed. When people did not eat their meal, staff brought them the alternative meal to encourage them further.
• People were given their meals on red or green plates which, because of the contrast, can make food more identifiable to people with a cognitive impairment. However, all the plates were plastic which does not keep food warm for people who eat slowly. All the plates were of the same flat design, and there were no aids available to support people to be more independent such as plate guards or adapted cutlery.
•On the day of our inspection, staff recorded what and exactly how much people had eaten and how much they had drunk. For example, we saw one person at risk of weight loss only ate 'two mouthfuls' of their main meal, but ate all their pudding and this was accurately recorded. However, there were gaps in the records for the previous day, which meant there was no reassurance about how the person maintained their dietary needs.
•Staff told us they offered people who were at risk of poor nutrition nourishing snacks throughout the day, such as milky puddings and drinks. We saw people being offered fortified milk shakes and cakes during the afternoon.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•A visiting healthcare professional was positive about the care people received. They told us, "They do exceptionally well here. They take really challenging patients. The décor is faded, but the care is superb. I explain to relatives about staff's attempts to keep people active and independent and manage risks."
•People's care records evidenced referral to other professionals to support people's healthcare such as doctors, district nurses and dieticians. However, this was not always done in a timely manner. For example, one person was at high risk of malnutrition. On the 22 December 2018 they weighed 7 stone. When they were weighed again on the 12 January 2019 they had lost 10lbs in weight, but they were not referred to the dietician until the 8 February 2019.
•We also found the advice of healthcare professionals had not always been followed. One person had been referred to the dietician due to weight loss. The dietician had recommended the person be given fortified snacks between meals. The person's food intake chart did not evidence this advice had been followed with only drinks being recorded in between meals on most days. We raised this with the manager who assured us they would remind staff to give the person snacks as advised.

Staff support: induction, training, skills and experience
•Staff told us they felt well-prepared for their role, because they had training in relevant subjects and spent time observing experienced staff before they worked independently. One member of staff told us when they started working at the home they 'shadowed' staff for three weeks to help them understand people's individual needs. Another member of staff told us, "I had to get to know people, know their ways."
•The new manager had already identified some areas in staff practice where they required more knowledge and support. Since January 2019, staff had received training in diet and nutrition for people living with dementia, falls awareness, infection control and supporting people at risk of skin breakdown. Senior staff were supporting staff to put their training into practice through competency observations.
•A member of staff told us they had been asked if they would like to complete the Care Certificate and had discussed their professional development opportunities with the manager. Staff told us they had 'more frequent' meetings since the new manager has started and more 'time to talk' about their practice. The manager was confident that with extra training and support, staff would have the competencies to ensure positive outcomes for everyone in the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•The assessment and recording of capacity and consent was variable. The registered manager from another of the provider's homes told us this was an area they had already identified required improvement and plans were in place to improve capacity documentation.

•Staff worked within the principles of the MCA in their interactions with people. People were given day to day choices and staff respected their choices. Staff asked people if they wanted to be supported before they acted to support them.

•Where people lacked the capacity to make everyday decisions, their care plans stated staff should make decisions in people's best interest, for example, what to eat and drink. At lunch time, we saw one member of staff showed a person both meal options, to help them in their decision making. Where people had a relative who knew them well and who visited regularly, their relatives supported them to make decisions about their food and drink.

•Due to people's needs, everyone living at the home had some restrictions within their care plans to keep them safe. Applications had been submitted to the local authority to ensure any restrictions were not unlawful.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity
•Staff were warm, respectful and responsive towards people and told us they enjoyed their role.
•We received positive comments about the caring and compassionate nature of staff. One relative told us the care staff were, "The best part, they never get cross" and another visitor said, "I see staff who are very attentive, nothing seems to be too much trouble for them." A visiting healthcare professional confirmed, "The carers are genuinely caring. They are always chatting, any time of day and give people hugs, it's quite individual."
•Our observations demonstrated that staff understood people's concerns and anxieties and were quick to offer reassurance.
•For one person who was at continuous risk of presenting behaviour that challenged others, there was always a member of staff by them to distract them and minimise risks to the person and those around them. The staff that were most skilled at this strategy encouraged the person to 'follow' them, rather than merely following the person around.
•Staff's behaviour showed that they shared their experience and understanding of people's emotional needs. For example, every member of the staff team who passed, stopped to speak with one person who needed to be regularly reassured by staff's speech or touch. One member of staff gave the person a hug and another member of staff made the person laugh with their conversation.
•Staff demonstrated a non-discriminatory approach to people and accepted people's individuality. When one person chose to sit on the floor during our visit, a staff member crouched next to the person and gently encouraged them to get up. When the person indicated they wanted to stay on the floor, the staff member gave them a drink and something to eat and continued to monitor the person's wellbeing.
•However, improvements were required to ensure people felt cared for within their environment. Some people's rooms did not provide a homely, comforting place for people to spend their time. Rooms were very basic and contained minimal decoration. There was an 'institutionalised' approach with most people having the same coloured bed linen and there was nothing in the rooms to remind the person of their lifetime experience and memories, or to give them a sense of belonging in the home.
•We found more could be done to ensure a person-centred approach to the delivery of care. Everybody was given their meals on plastic plates and bowls. People's individual needs and abilities had not been assessed.

Respecting and promoting people's privacy, dignity and independence
•Improvements were required in respecting people's privacy and dignity. The lounge at the front of the building and several ground floor bedrooms faced out onto the street. Although, there were curtains, there were no other forms of window covering to protect people's privacy and dignity, especially if they chose to

stay in their bedrooms during the day.
•Many of the bedroom doors we looked at did not have door catches or locks, which meant people were at risk of others walking into their bedroom uninvited and unhindered.
•There was a lack of respect for people's personal possessions. One relative told us they had complained to staff because some of their relation's clothes had gone missing, and one item was found in another person's room. Five items of their relation's clothes had been damaged, but they had been given no explanation as to how the damaged occurred.
•Individually staff promoted people's independence, for example, by offering drinks in spouted cups, or with a straw, so they could drink independently. We saw staff encouraged one person to drink by showing them their tea cup and wrapping the person's fingers around the cup, to remind them how to lift it.
•People's family and friends were encouraged and relatives could visit when they wished. People were supported to spend time together when they showed signs of friendship towards each other.

Supporting people to express their views and be involved in making decisions about their care
•People were involved as much as they could be in making decisions about their care and staff supported them to decide what they wanted to do. For example, people could make choices about how they spent their day. On the day of our inspection visit, one person was having breakfast when we arrived, but others were already up and about.
•Staff asked questions such as, "Can I help you with that?" and, "Are you comfortable?" so people were involved in deciding whether they wanted support or assistance.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Each person had a care plan which detailed the support they needed to maintain their health and meet their needs. However, care plans were very problem orientated rather than enabling and focusing on maintaining skills and independence and ensuring people kept their own personal identity.
•The manager told us they had already identified care plans needed to be more person-centred and started working on this. They had re-introduced the 'resident of the day' when each month every person in the home would have a review of all their care needs. This would be a holistic review including people's risks, health, emotional and social needs, environment and dietary preferences.
•Staff were responsive when people started to become anxious, ill at ease or demonstrated behaviours that challenged the service.
•Staff kept records to monitor some people's behaviours when they became challenging. These were called 'ABC' charts. However, we found that sometimes staff had recorded behaviours on the charts that were not challenging and had no impact on staff or other people around the person. No-one was responsible for analysing the ABC charts to identify any triggers for people's agitation, which could have resulted in changes to the environment or to how staff responded to people, to minimise the risks of a reoccurrence.
•There was an activities co-ordinator who worked in the home three days a week. On the days they were not working, care staff were responsible for providing people with opportunities for meaningful occupation.
•The activities co-ordinator was not working on the day of our inspection and in the morning, we saw several people asleep in armchairs. We did not see people engaged or occupied in individual or group activities. During the afternoon, care staff encouraged people to throw a ball back and forth, but many people did not join in. One person had a puzzle on a side table, which they did not pick up, but no staff sat with them to encourage them to complete it. Another person had a box of dominoes on a side table, but no staff attempted to play dominoes with them. The person twice pushed the dominoes off the table.
•The manager acknowledged that the provision of meaningful occupation in the home needed to be improved, both through the environment and staff interacting with people. They told us they had already increased the activity co-ordinator's hours and were planning to recruit a new staff member to increase activities in the home. They added, "It needs to be improved, that is why we need to raise the awareness of staff to interact with people."
•Each person's preferred communication methods were recorded in their care plans. Records showed staff ensured people's sensory needs were met with the involvement of opticians and dentists.

Improving care quality in response to complaints or concerns
•The provider had an established complaints procedure and process in place.
•There was only one complaint in the complaints file for 2018. This had been referred to the Office of the Parliamentary and Health Service Ombudsman (PHSO), because the complainant was not happy with the provider's response to their original complaint.

End of life care and support

•There were no end-of-life care plans in place. A nurse told us they had not created end-of-life care plans, even though one person was technically towards the end of their life.

•The manager had recently completed a two-day training course in palliative care and was confident they could meet people's needs in their final days.

•People did have appropriate documentation in place regarding decisions about interventions in the event of a cardiac arrest.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
•Governance and oversight systems had failed to ensure the provider was mitigating risks to people in relation to their care. The provider had not ensured there were appropriate systems in place to check the daily records made by staff to ensure people received the care and treatment they needed.
•Managers and senior staff had not taken responsibility to analyse information available to them, in particular ABC charts, to identify any triggers to people's episodes of challenging behaviour, with a view to minimising the risk of a reoccurrence.
•The provider's systems in place to monitor the quality and cleanliness of the environment and infection control had not resulted in a safe environment where environmental risks were adequately managed. The provider had failed to take timely action to make the required improvements in the environment identified at the last inspection visit in August 2016.
•Although the provider had a number of quality assurance processes in place at the service, these had not been effective in identifying the number of significant shortfalls in safety and quality. For example, they had not identified the environment was not satisfactorily maintained, inviting or fitting for people living with dementia.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The manager had only been working in the service since 7 January 2019 but was open and transparent about the improvements that needed to be made to ensure everybody in the home received high standards of care. They told us there was a number of competing priorities and it would take time, but they assured us they would make those improvements. For example, when talking about the environment they told us, "It needs to be improved, but there are a lot of other things I need to prioritise at the moment. The environment is a bit institutionalised and that is what we want to change."
•An area the manager had identified as a priority for improvement was clinical oversight of the home. They had already implemented clinical audits of hospital admissions, skin integrity, nutritional needs and accidents and incidents. They told us this oversight would enable them to identify any trends and patterns and identify any areas where improvements were required or people required further input from other healthcare professionals.

•The manager had introduced a 'daily walk around' to look at staffing, the environment and staff practice. They had also introduced 'flash meetings' once or twice a week so senior staff could discuss any issues and any areas where improvements were required.
•The manager was aware of their responsibility to provide people with safe, effective care and although a recent placement stop by commissioners had been lifted, they told us they would not accept any new admissions until, "I feel it is right."
•Staff spoke highly of the new manager and the impact they had already had on the home. One staff member told us the new manager had already implemented some changes with had benefited people. They told us, "She got rid of the chairs (in the lounges) because they were ripped, there have been more activities going on and there are a lot more staff meetings."
•Staff told us the manager was approachable and encouraged them to discuss their practice and their professional development. They told us there had been more training opportunities in the previous four weeks, more supervision and observations of their practice. One staff member told us, "She is a good manager, she knows how to work with the staff and communicate with us. When something is wrong, she talks to you and will help you to do it right." The manager commented, "The staff are very caring but you need to nurture them and give them the right knowledge and resources."
•Confidence in the new manager was shared by relatives. One relative told us, "[Name of manager] is turning things around." Another visitor said that when they first visited the home, they had concerns. However, they went on to say, "The more I come the better it is. I do think they are improving.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•The provider had undertaken a quality assurance survey in 2018. Questionnaires had been completed by relatives and staff. Results recorded a high satisfaction rate across the service, however the level of satisfaction reported was not reflected by our findings during our inspection visit.
•The provider facilitated opportunities for staff to share their views about the service through staff meetings and the new manager had plans to involve staff further. Minutes of meetings showed they were used as an opportunity to share good practice. One member of staff told us, "The meetings are really good and helpful. [name of manager] gets us to speak for yourselves. She will ask if there is anything we need to get off our chests."

Continuous learning and improving care; Working in partnership with others
•The manager had signed up to a social care and development partnership with the local authority. The partnership enables providers of services to access guidance and funding to enhance staff development. Staff had already accessed some of the training available to support their practice.
•The manager had formed links with other healthcare professionals to support staff learning. For example, the infection prevention nurse had recently delivered training on infection control.
•Following a person falling in their bedroom, the provider had introduced movement sensors into bedrooms which alerted staff if people at risk got out of bed unaided.
•The manager was exploring best practice in other organisations to improve outcomes for people. For example, they were reviewing a new assessment tool which would more effectively identify people's protected characteristics under the Equalities Act 2010 and their interests and any cultural needs.
•The provider and manager were working with the local commissioners and the local clinical commissioning group to improve outcomes for 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately protect people against risks by doing all that was practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems were not always effective in assessing, monitoring and mitigating the risks to people who used the service.