Bupa Care Homes (CFChomes) Limited

Tadworth Grove 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

About the service
Tadworth Grove 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. Tadworth Grove is registered to provide accommodation and nursing care for up to 45 people, some of whom are living with dementia. There were 40 people living at the service at the time of our inspection.

People's experience of using this service and what we found
There were not always enough staff to meet the needs of people. Although people received their care when needed in the mornings, the number of staff on site reduced in the afternoons which impacted on the care. This particularly affected those people that were in their rooms, as there were insufficient meaningful activities for people that were at risk of social isolation. The registered manager told us they had increased staff levels since the inspection. We will check the impact of this on our next inspection.

People were not always supported to have maximum choice and control of their lives and support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. The registered manager contacted us after the inspection to confirm that the capacity assessments that were not in place for people that were unable to leave the service were being undertaken and staff were to receive updated training in the principles of the mental capacity act.

Staff told us that they felt supported and records identified staff were up to date with their training. However, not all staff had received the required one to one supervision with their manager as per the providers policy. We have made a recommendation around this.

People and relatives told us that there were not sufficient activities and outings. We found that there needed to be more meaningful activities and outings that were planned around the interests that people had.

Improvements were required around how records were maintained and the robustness of the quality assurance checks that took place. This included fluid charts not being totalled and the accuracy of the care plans.

Staff were knowledgeable about the risks associated with people's care. There were plans in place to protect people in the event of a fire or if the building had to be evacuated. People received their medicines when needed. People told us that they were supported with all healthcare needs and records confirmed this. People and relatives told us that staff were kind, caring and respectful towards them. We observed examples of this during the inspection. People were supported and encouraged to remain as independent as possible and were involved in decisions around their care. Relatives and visitors were welcomed into the service.

Care plans were designed around people's wishes and included information on people's backgrounds.

People and relatives knew how to raise a complaint and were confident that complaints would be listened to and addressed. People, relatives and staff thought the leadership of the service was supportive and always visible. Staff told us that they were encouraged to be involved in the running of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Previous Inspection
The last rating for this service was Good (Report published 9 September 2017). Although it was rated Good; the service had a previous breach that related to the lack of decision specific mental capacity assessments. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about people not being supported with drinks and lack of staff. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of a specific incident, following which a person using the service died. This incident had been subject to an investigation by the coroners.

The information CQC received about the incident indicated concerns about the management of supporting people that were at risk of dehydration. This inspection examined those risks.

Follow up
We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. We asked the provider to mitigate the risks in relation to staff levels and ensure people were provided with sufficient hydration. They have assured us that this has been addressed.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information 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.

Tadworth Grove 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Our inspection was completed by two inspectors, a nurse specialist 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.

Service and service type
Tadworth Grove 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager and the senior manager team were present on the day of the inspection.

Notice of inspection
This inspection was unannounced. We inspected the service on the 24 July 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. On this occasion due to us inspecting sooner that was planned we did not ask the service to complete a Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with 13 people who used the service, six relatives and three volunteers about the experience of the care provided. We spoke with the registered manager, and members of the senior management team. We also spoke with seven members of staff including nurses and care workers. We also observed care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People and relatives fed back that they did not feel there were enough staff. One person said, "There is never enough [staff]." Another said, "There are not enough staff on this floor."

● This was reflective of our findings on the day where we found there were not sufficient staff to meet the needs of people. In the afternoon people in their rooms were not being supported with their drinks or meals due to the lack of staff available. We heard a person in their room say they were thirsty. No staff were available and a visitor, with a person in a near-by room, came to assist them with their drink.

● We observed two people were given their meal in their room at 13.05pm and at 13.30pm neither meal had been touched. This was because staff were not available to assist them, despite the need for assistance at meal times being stated in their care plans. Staff told us that it was difficult to provide the support people needed to eat as they were so rushed. One staff member told us, "The mornings are okay, but it's sometimes difficult in the afternoon."

● The registered manager told us two care staff were required to be in the lounge with people in the afternoon. We observed for most of the afternoon only was carer was in the lounge as the other member of staff was assisting people in their rooms. The registered manager told us that they had also picked up on this and found the second member of staff was in another part of the service. Staff told us they were rushed and were not always able to perform all the duties required. One told us, "If the nurses aren't doing the medicines, they come and help so that's a bonus."

● The registered manager told us that staff levels reduced in the afternoon. When we asked them why this was they advised us that this was common practice and not uncommon for other care providers. They were unable to explain how the staff levels had been determined in the afternoon or whether this was based on the needs of people. They also acknowledged with us that in the afternoon a lot of people required support from staff to take them to the bathroom.

As there were a lack of staff to support people's needs this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the morning of the inspection, there were sufficient staff to support people when they needed. We observed that when people required staff assistance they were supported quickly.

● There were appropriate systems in place that ensured that only suitable staff were employed. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people.

● After the inspection, the registered manager advised us, "I have agreement from the senior management team to increase the staffing levels at Tadworth Grove with immediate effect based on my current

occupancy and needs of my residents." We will check this at our next inspection.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were assessed regularly to ensure that people were kept safe. Care plans contained up to date and relevant information concerning the risks associated with mobility including bed rails risk assessments and risk of choking.
● Clinical risks were identified, and plans were developed to reduce the likelihood of them occurring. For example, where people had been identified as having a higher risk of pressure sores there was a skin integrity care plan to reduce the risks.
● People living with diabetes had their blood glucose levels monitored regularly and there were records of the administration of insulin. Health files and progress notes evidenced that people with diabetes were being monitored by nurse specialists and the GP.
● Each person had a Personal Emergency Evacuation Plan (PEEP) which outlined how the person could be removed or kept safe in the event of an emergency, such as fire or flood and staff were aware of these. There was a file in reception that could be accessed quickly in the event of an emergency which was updated regularly. There was a service contingency plan so that in the event of an emergency people could be evacuated to neighbouring services.
● Incidents and accidents were recorded with action taken to reduce the risks of incidents reoccurring. A sensor mat had been placed next to the bed of one person who had fallen on numerous occasions, so staff knew when they were out of bed. This had reduced the amount of falls the person had.

Using medicines safely
● Medicines were managed in a safe way and people told us that they received their medicines when needed. One relative said, "Her [their family member's] medicines were a mess. [The nurse] sorted it all out and now she's virtually on nothing. That is how it should be done."
● People's medicines were recorded in Medicine Administration Records (MARS) and reflected people's current medical treatment. There was evidence that 'as and when (PRN) medications were being given appropriately, such as when people were in pain.
● The medicine room was securely locked, and the fridge temperature was checked daily to ensure it was at a safe temperature which would not jeopardise the effect of the medicine.
● Medicine competency checks took place to ensure that staff were appropriately administering medicines.

Systems and processes to safeguard people from the risk of abuse
● People told us that they felt safe with staff. One person said, "I do feel safe as I do need quite a lot of help." Another person said, "I was worried about having a male when I first moved in. But now, if a male staff member came to me I would not be worried at all."
● Staff were aware of the types of abuse and what they needed to do if they suspected anything.
● Staff were up to date with safeguarding training and there was information on the staff notice boards reminding staff of their duties to safeguard people.
● We saw that where concerns were raised, the registered manager had referred this to the Local Authority and had undertaken a full investigation.

Preventing and controlling infection
● People told us the premises was always clean. One person said, "My room is kept clean. The laundry is done well." Staff were seen cleaning the service throughout the inspection.
● People were protected against the spread of infection within the service. There were hand gel stations on each floor for staff and visitors to use. Staff were seen wearing Personal Protection Equipment (PPE) where needed.

● A regular infection control audit took place to ensure that staff were adhering to the correct procedures.

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.

This meant the effectiveness of people's care, treatment and support was inconsistent.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. At the previous inspection staff were not always completing decision specific capacity assessments for people where it was required. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that this had improved although there were still some shortfalls.

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.

- At the time of the inspection appropriate MCA assessments had not always been completed related to locked doors. The registered manager told us that the senior staff were archiving mental capacity assessments for locked doors if the person was not indicating that they wanted to leave. However, this was not the case for people who more recently had moved in to the service where a MCA capacity had not taken place at all.
- Staff were not always knowledgeable in the application of the MCA and its principles. One told us, "I'm not too sure (about the MCA). Some people take longer to understand, and I give more time to [person] for them to explain things to me." They had not considered that MCA aims to protect people who lack capacity and maximise their ability to make decisions or participate in decision-making. The Act is underpinned by five statutory principles. The member of staff was not able to tell us these.
- After the inspection the registered manager told us that further training was going to take place for staff around MCA. They also told us any remaining capacity assessments for the locked doors were taking place along with best interest meetings.
- We saw examples of where appropriate assessments of capacity had taken place with evidence of best interest meetings. This included assessments around medicines, capacity to consent to care and the taking

of photographs.

Staff support: induction, training, skills and experience
● Staff members had not always received appropriate support to promote their professional development and to assess their competencies. The registered manager told us that at least four one to one supervisions needed to take place for each person every year that included two appraisals. However, staff records confirmed staff had only had one supervision this year and other group meetings with staff had been incorrectly recorded as one to one supervision. The registered manager told us, "I agree that the one to ones must have been team meetings. I agree that there should be one to ones for these staff and that they are behind."
● We saw evidence that nurse staff met with the clinical lead to discuss all aspects of clinical care. There was also support from a senior nurse from another BUPA service that visited the service to provide clinical supervisions for nurse staff.
● Staff however told us that they received support from their line manager. One member of staff told us, "I have had a lot of support and feel really welcomed here." They told us they could speak to the line manager whenever they needed to if they needed to talk through their work.
● Staff completed a full induction when they first joined the service and shadowed a member of staff to understand the role and what was expected of them. One member of staff said, "The regular staff are well trained. The induction was really helpful to be fair."
●Training was up to date and included areas such as moving and handling, safeguarding and infection control. Clinical staff had regular training and reflective practice to review their clinical skills. This included training and discussions on wound care, catheter care and end of life care.

We recommend that the frequency of staff supervision is reviewed in line with the providers policy.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● Assessments of people's needs were undertaken before people moved in. This was to ensure that their needs could be met once living at the service. Assessments included information about communication, allergies, medical background, weight, dietary needs, mobility, memory and cognition. Information from the pre-admission assessment was then used to develop care plans for people.
● People were offered a selection of hot meals and alternatives were available if people wanted something different. One person told us, "There are always omelettes and sandwiches offered if I don't like what's being offered." Another said, "The food is very good."
● The chef was provided with information about people's dietary needs. This included if meals needed to be modified, such as pureed for people who were at risk of choking, and those that had allergies.
● People were weighed monthly and more frequently if required. Health care advice was sought if people were losing weight.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People told us they had access to health care professional support and they received effective care at the service. One person told us, "When I came, I was looked after by a [nurse name]. She was wonderful, and I am now out of end-of-life care because of the attention she gave to get me to this stage."
● Staff worked with health care professionals in support of people's care. We evidence of involvement from the GP, Tissue Viability Nurse (TVN), physiotherapist and nutritionist.

Adapting service, design, decoration to meet people's needs

● The environment was set up to meet their needs of people. There was appropriate signage on the bathrooms and toilets for people that were living with dementia. The corridors were wide to allow easy access for people that were wheelchair users.
● Chairs were arranged in clusters in the communal areas to encourage conversations. The garden was large and accessible for people.
● Each room had an ensuite and people were able to have personal effects including furniture in their bedrooms.

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

This meant people were supported and treated with dignity and respect; and involved as partners in their care. However, there were times that people were left socially isolated and people in their rooms did not always have the support they needed.

Ensuring people are well treated and supported; equality and diversity

● There were people at the service that were being cared for in their rooms, and at great risk of social isolation, that did not have interaction with staff as often as they should. Staff were busy elsewhere and did not have as much time to spend with people as they would have liked.

● However, people and relatives told us that staff were kind and caring towards them. One person told us, "Staff are kind. They help me get up in the mornings and go to bed." Another told us, "The staff are so kind and caring. They are brilliant."

● We observed staff were kind and considerate to people throughout the day. One person wanted to sit in reception. The member of staff said, "Here let me get you a drink [person's name]. You will be able to hear the music entertainment from here as well."

Staff greeted people warmly when they went into their rooms and when passing them in the corridor.

● Staff were polite towards people when delivering care and support. One member of staff entered the room of a person that was anxious because their hearing aid was not working. The member of staff fixed the equipment and said, "Is that comfortable for you? There you go." The person smiled and thanked the member of staff.

● There were religious services planned for people of various dominations. This included services at Tadworth Grove and people attending services outside. One person told us, "She [member of staff] is very Christian which I like. She prays for me which I thank her for."

● Relatives and friends were welcomed to visit and maintain relationships with people. We saw relatives arrive at the service and were greeted warmly by staff. One person told us, "I have children and grand-children and it's good that I can be with them here."

We recommend that the provider looks at ways of considering how people in their rooms have regular contact with staff to reduce the risk of social isolation.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence:

● People told us that they felt involved in their care planning. They said they were asked what time they wanted to get up and go to bed, whether they preferred a male or female carer and what their interests were. This information recorded in their care plan. One person told us, "I get to choose what to wear and ask for a bath if I want."

● People and relatives told us that staff were respectful. Staff called people by their preferred names and developed respectful relationships with people. One person told us, "[Staff member] is brilliant. She is worth

her weight in gold."

● Personal care was provided behind closed doors to protect people's dignity. We observed staff knock on people's doors before they entered.

● Staff encouraged people to be independent where possible. We heard staff encouraging people to eat their meals whilst in the dining room. One person told us, "I have full cognition. I go out independently." They told us that they were given the code to the door so that they could go out when they wanted.

● When people became disorientated due to them living with dementia staff were calm, reassuring and listened to what the person had to say.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People told us there were not enough activities and outings available. Comments included, "There's not enough to do. I'd love to go out", "I can't get out of bed on my own and here all the time makes me feel so lonely" and "They get you up and sit you in a room. Going out is never pleasurable, just hospital."

● Improvements were required to ensure that activities were meaningful and kept people occupied. People were offered activities outside of the planned entertainment, but these were not always specific to people's individual hobbies and interests.

● Some people were cared for in their rooms either through personal choice, illness or infirmity. There was no evidence that activities had been planned to ensure these people did not experience social isolation. One person said, "It's a case of, 'get X [person] washed and sat in the room' and that's where I stay."

● The weekly activity programme stated there were coffee mornings six days a week with sherry on the seventh morning, hairdressing, podiatrist, and manicure each week. There were also three afternoons of, "quiet time with tea and cakes". These activities were not person centred. A 'knit and natter' was advertised but the only person knitting was the volunteer. The registered manager told us that activities needed to be improved and that hairdressing and podiatrist should not be recorded as an activity. They said, "Activities could be improved, particularly outings."

● The providers website and information leaflet stated that there were a number of activities and outings that took place. However, this was not always taking place. An internal audit on the 23 July 2019 [the day before the inspection] also identified that, "There is very minimal evidence that people nursed in bed are having appropriate stimulation and interaction."

As there was a lack of meaningful activities, designed to meet people's needs and preferences, this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

● Care plans were developed around people's care and support needs. There was detailed background information around people's likes/dislikes, backgrounds including previous careers, their family history and hobbies and interests. One member of staff told us, "I also take note of people's specific drinks, like one lady who likes blackcurrant. She drinks more of less the whole jug herself over lunch as most people like orange juice."

● Staff understood the care that needed to be delivered to people. Staff were able to explain the wound care that people needed and how people preferred their care. One member of staff said, "He [person] can't sleep lying down, he needs to have his feet out on the floor on top of towels." The person confirmed that occurred.

● Staff told us that they completed a handover session after each shift which outlined changes to people's

needs. Information shared at handovers related to a change in people's medicine, healthcare appointments and messages to staff. Daily records were also completed to record the care people received each day. One member of staff said, "I learn about people at handover and then I start to memorise it."

● End of life care was planned around people's wishes. Information in the care plans included people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.

Improving care quality in response to complaints or concerns

● Complaints and concerns were taken seriously and used as an opportunity to improve the service. People and relatives told us that they knew how to raise a complaint. One relative said, "There is a plenary where you have the opportunity to raise anything. I know if I did it would be sorted."

● Complaints had been investigated thoroughly and people and their relatives were satisfied with the response. For example, one relative complained that were not enough staff at night. The registered manager undertook a full investigation and wrote a letter to the relative to confirm that this had been addressed and additional staff were put on at night. People and relatives had fed back that there was a lack of management presence at the weekend. As a result, the registered manager changed their shift to include one day on each weekend.

● Compliments were also received by the registered manager. One feedback form stated, "The displays in reception are always outstanding. They are imaginative and beautifully arranged."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Each care plan detailed how best to communicate with the person. One person's care plan stated that the person's speech was quiet and that their hearing had been affected. Staff were advised to speak clearly and slowly on their right side and we saw staff doing this.

● Information was available in larger print and where necessary, interpreting services were available for people whose first language was not English.

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.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Information relating to people's care was not always up to date or accurate. Where people were at risk dehydration fluid charts were put in place. However, there was no target information recorded on the charts so that staff could identify if people had drunk enough for the day to prevent dehydration. The provider's 'hydration' policy stated that staff should be, "Aiming for an amount that is relevant to their individual drinking pattern" and that this amount should be, "Clearly documented in their care plan." This policy was not being followed. The registered manager told us, "I need to do some work on people's fluid intake. Take an average of what people take over a period of five days, then make that the target."
- The record that staff were using during handover did not always have the most up to date information on people's needs. This meant that staff may not provide the correct care. For example, the handover sheet stated that one person's skin was 'intact'. However, a nurse advised that this had not been the case for at least a week. The registered manager told us that they had not updated the handover sheet for at least two weeks. Although this had not had a direct impact on people there was a risk that the most appropriate care was not going to be provided.
- Care plans were not always updated in relation to people's up to date needs. For example, one person's care plan had their weight recorded incorrectly. Another person's care plan stated that the person needed support to eat their meal. However, a member of staff told us that the person could eat independently. There were activity records that had not been completed since June 2019 despite activities being provided to the person.
- Care plans did not always have detailed guidance in relation to people's health conditions. For example, one care plan stated that the person had an unusual condition. It had been spelt incorrectly on the care plan and there was no information about what this condition was and how it affected the person. Although staff on duty knew what this was there was a risk that new and agency staff would not know.
- Leadership within the service was not robust. There was no system in place to ensure that the seniors on each floor of the service were ensuring that the most appropriate care was being provided. Nurses were required to sign off the food and fluid charts each day. This was not always being done. There were repeated reminders in staff meetings both for the nurses and general staff to ensure that fluid charts were completed. However, this had still not been fully addressed and resolved. The registered manager told us, "Recording is an issue. People come down [from their bedrooms] and they are being offered drinks by other people, but because the chart is in their room it's not recorded." They told us that they were addressing this with staff in group supervisions.
- Audits that took place were not always revisited to ensure that the actions identified had been addressed. A care plan audit that took place 9 June 2019 identified gaps in one person's care plan. Of the four things

identified only one of these had been addressed on the day of the inspection. This included an out of date photo and lack of evidence that the nursing staff had reviewed the daily notes.

As records were not always being maintained accurately and quality checks were not always robust or effective this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and staff were complimentary about the registered manager. One relative said, "The registered manager is nice and approachable, and I can talk to her if I was unhappy about anything." A member of staff said, "The manager checks on everyone which is great. There have definitely been improvements, such as changing the layout of the lounge. It's better for residents and staff."
● There were elements of the quality assurance checks that were effective in ensuring quality of care. Audits were completed around care being provided that included people's skin integrity, falls, infection control audits, medicine audits and health and safety audits. We that where people were losing weight this had been reviewed and appropriate health care professionals were sought. We saw from a medicine audit that 'as and when' guidance needed to be updated for a person's medicine and we saw that this had now been done.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were invited to attend meetings to feedback on any areas they felt improvements were needed. One person had requested alternative starters with their meals and this had been done.
● As a result of a recent survey with people and relatives, the registered manager introduced an electronic tablet so that people were able to contact their family and friends with face to face contact messaging.
● Regular staff meetings took place to discuss any concerns they had or raise useful suggestions to make improvements. It was agreed through discussions with the senior management team and nursing staff they would not admit people with complex needs due to their being a high level of people with complex needs already at the service.

Continuous learning and improving care; Working in partnership with others
● Where incidents had occurred, staff had reflective practice discussions to look at ways of improving the quality of care. For example, there had been a medicine error which had been discussed with staff and actions put in place to reduce further risks. This included nurses being more vigilant and ensuring people going out for the day were having their medication given before leaving.
● The provider and registered manager worked with external organisations to drive improvements in care. The service liaised with other organisations such as Princess Alice Hospice, the practice manager at the local GP and Oomph (an activity provider). We saw from meeting minutes with the practice manager that they looked at ways of improving the referrals to the GP practice. We saw that this had been implemented.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager ensured that they shared information with people and their families. Relatives told us that they were also contacted if there had been any concern in the way care had been delivered to their family member.
● Duty of candour reports were completed after any incident with information detailing how the incident occurred, the investigation and who was contacted. The registered manager ensured that this were reported to the CQC where required.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that there were enough meaningful activities, designed to meet people's needs and preferences.

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 had not ensured that records were being maintained accurately and that quality checks were always robust and effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were enough staff to support people.