Sussex Clinic Limited

Sussex Clinic

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Sussex Clinic on 28 November 2017. Sussex Clinic is registered to provide nursing care to up to 40 people, some of whom were living with dementia and other chronic conditions. The service comprises of three converted houses, with a lounge and dining areas. There were 30 people living at the service during our inspection.

We previously carried out a comprehensive inspection at Sussex Clinic on 28 September 2016. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation to the management of medicines and the provision of meaningful activities. The service received an overall rating of 'requires improvement'. After this inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan, and confirm that the service now met legal requirements. We found improvements had been made in the required areas. However, we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for Sussex Clinic remains as 'requires improvement'. We will review the overall rating of 'requires improvement' at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been made and sustained.

A registered manager was not in post and day to day management of the service was provided by an acting manager who was a registered manager of another service within the group. 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 and associated Regulations about how the service is run.

Some staff had received essential training and there had been opportunities for additional training specific to the needs of people. However, we saw that several members of staff had not received essential updated 'refresher' training in a timely manner. This is an area of practice that needs improvement.

There was a range of quality assurance systems to help ensure a good level of quality of care was maintained. However, these systems had not fully ensured that people received a consistent and good quality service that met their individual needs.

We have made a recommendation about systems being implemented to comply with the Accessible Information Standards (AIS).

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed

appropriately.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, book reading, massage and manicures and themed events, such as reminiscence sessions and visits from external entertainers. People were also encouraged to stay in touch with their families and receive visitors.

People were being supported to make decisions in their best interests. The acting manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who received training and supervision. However, some essential training had not been updated in a timely manner.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their

independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them. Peoples' end of life care was discussed and planned and their wishes had been respected.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems of audit and quality monitoring did not always identify areas that required improvement.

People, relatives and staff spoke highly of the service. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement. Staff had a good understanding of equality, diversity and human rights.

Sussex Clinic

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 28 November 2017 and was unannounced. The inspection team consisted of one inspector 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. The expert-by-experience for this inspection was an expert in care for older people.

The 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 they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining areas of the service. Many people could not fully communicate with us due to their conditions, however, we spoke with six people, five relatives, three care staff, the chef, the deputy manager and the acting manager. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection on 28 September 2016, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were inconsistencies with systems and the way that the staff managed medication. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made and the provider was now meeting the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified concerns in relation to the use of topical creams, gaps and omissions in medication administration records (MAR) and staff following the appropriate procedure for administering and signing for medication given. We looked at the management of medicines. Care staff and registered nurses were trained in the administration of medicines. A member of staff described how they completed the medication administration records (MAR). We saw the MAR's were accurate. We saw further documentation to show that staff recorded the dates that they opened topical creams to ensure they were appropriate for people to use. The acting manager told us, "We have carried out a lot of medication audits, plus looking at and recording levels of stock. We have also been over the procedures with staff for signing for medication. We date creams when opened and use a creams chart". We saw this was the case and regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed three members of staff giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "The nurse gives me my medication. Absolutely on time". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

People said they felt safe and staff made them feel comfortable, and that they had no concern around safety. One person told us, "Yeah, I just feel safe". Another person told us, "Yeah, they look after me, it's my home. I have been here three years".

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training and this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people. Documentation showed that the provider cooperated fully and transparently with relevant stakeholders in respect to any investigations of abuse.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The

acting manager told us how staffing levels were amended to ensure that staff could attend training and ensure that they were up to date with the service's policies and procedures. Management staff were also given supernumerary time to ensure that paperwork was completed in a timely manner. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "Promptly as I can expect, they are very good, they are always on time". Another person said, "They are busy but they are pretty good when they can, you have to understand they have a lot of people to look after". A member of staff added, "There's always enough staff to look after people". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the nursing midwifery council (NMC).

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the service and its equipment were clean and well maintained. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. A relative told us, "They are very nice people, its clean, [our relative] seems quite content here, which makes us happy ". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves was readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The acting manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "Happy as you can be, I don't need any more than what I am getting". Another person said, "I choose my clothes and staff always ask me for permission". However, despite the positive feedback, we identified areas of practice that need improvement.

Staff told us the training they received was thorough and they felt they had the skills they needed to carry out their roles effectively. Training schedules confirmed some staff received essential training on areas such as, fire safety, moving and handling, safeguarding adults, health and safety, food hygiene and infection control. Some staff had also received training that was specific to the needs of the people living at the service, this included caring for people with dementia and palliative care (end of life). Registered nurses received on-going clinical training which also maintained their continuing professional development. Systems were also in place to support nursing staff to revalidate with the Nursing and Midwifery Council (NMC).However, records showed that a number of staff had not received updated 'refresher' training in a timely manner and equality and diversity training had not been delivered to any staff. We saw that updates were required for staff in topics including moving and handling, safeguarding adults, the Mental Capacity Act 20015 (MCA), falls awareness, dementia awareness, challenging behaviour, diabetes awareness and palliative care. We raised this with the acting manager who told us that the training records were not up to date and that most of the training had gone ahead. However, we did not see evidence to confirm the training that had been given to staff.

Updates of relevant training are important to ensure that care staff remain up to date with sector specific information, such as any new legislation and good practice guidelines within the sector. The above evidence demonstrated that people were placed at risk as the provider could not demonstrate that relevant training, including updates had been given to staff in a timely manner. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who

were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment was used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. These are called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "I have a girl coming in my room doing my feet once so often". A relative added, "I am extremely happy with the medical care they receive". Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured when people were referred for treatment they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. A GP was visiting the service on the day of our inspection, and we saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "Very good usually, they give you too much sometimes". A relative added, "From what I have seen it is perfectly adequate, food looks good, well prepared and presented". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Staff had liaised with Speech and Language Team (SALT) to ensure that specialist diets were catered for, such as for people who required pureed food. Nobody at the service required a culturally appropriate diet. However, staff stated that any specific diet would be accommodated should it be required.

People's individual needs were met by the adaptation of the premises. The service comprised of three converted houses, with an accessible garden, lounge and dining room. Floors had been fitted with ramps to

assist people to mobilise safely, hand rails were fitted throughout the service, and other parts of the service were accessible via a lift. There were adapted bathrooms and toilets and hand rails in place in these to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "[The staff are] very caring because anything that you want they will do it". A relative added, "Staff are very friendly, very calm. Rooms are spacious and clean, and [my relative] has brought some of her furniture from home, so she can feel homely".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "Sometimes I choose, sometimes they choose". Another person said, "Oh yeah, I have choice on it [care delivery]". A relative added, "They respect [my relative's] wishes if she doesn't want to do something". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "People have routines they choose, we offer choice". Another added, "We always ask people what they want and what they want to do".

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "They [staff] are just so good". A relative said, "They [staff] are always there when he needs them". A member of staff added, "We get to know people and they get good care, that's the best thing. Their family gets good hospitality too. It's a good service".

People's equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. For example, staff told us how they adapted their approach to sharing information with some people with communication difficulties. One member of staff told us, "We write things down on paper for people and some lip read". Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. A relative told us, "They know what [my relative's] needs and are always there for her". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk

about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food. Most staff also knew about peoples' families and some of their interests.

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. When asked about their privacy being respected, one person told us, "Oh yes, they are very good". A relative added, "They treat [my relative] with more than respect, with care, love and compassion".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. For example, some people managed their own medication, which helped them to continue making daily living choices. One person told us, "I do still take my medicines myself". In respect to independence being promoted, a relative said, "100% and they do more than the extra mile". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "We encourage people to do things for themselves, like getting dressed".

Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way friendships were formed within the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. One visitor told us, "The staff are our friends". Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together.

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us, "Sometimes the Minister of Horsham comes to see me". Another person said, "Sunday services are planned I think".

Good

Is the service responsive?

Our findings

At the last inspection on 28 September 2016, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation the provision of meaningful activities. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made and the provider was now meeting the legal requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found the provision of meaningful activities for people were not consistently based on their assessed need and personalised to them. The acting manager told us, "Due to their conditions, many people choose to remain in their rooms, so we ensure that one to one time is always scheduled for them. Some people do enjoy group activities and we have activities scheduled every day". We saw evidence of people taking part in activities, which included one to one time scheduled for people in their rooms, book reading, massage and manicures and themed events, such as reminiscence sessions and visits from external entertainers. People were given the choice to join in activities, or alternatively not take part should they not want to. The service also supported people to maintain their hobbies and interests and achieve specific goals. For example, one person enjoyed classical music and staff ensured they listened to this every day. Another person wished to remain in their room and records instructed staff to look through photos with them and discuss nature programmes, as this is what they enjoyed. On the day of the inspection, we saw activities taking place for people. We saw people taking part in a book reading. People were clearly enjoying the activity and often engaged with other people in the room and the person reading the book aloud.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Nobody at the service who received funding had specific communication needs. However, staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. One member of staff told us, "We have a translator available if needed". However, staff were not aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. A relative told us, "Staff asks you to update it [care plan] time and again, any comments about my [relative] were included in the care plan". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "I've read the care plans and we update them

and communicate any changes to all staff". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan.

Technology was used to support people to receive timely care and support. The service used a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time, and raised no concerns in relation to staff responding to their needs.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. A relative told us, "I would talk first to the nearest staff member, then if not solved, I will approach the manager or her deputy". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

People's end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. The service also liaised with a local hospice to share learning and advice, and had a designated end of life care champion.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the acting manager and felt the service was well-led. Staff commented they felt supported and could approach managers with any concerns or questions. One person told us, "I would recommend this service to a friend". A relative said, "I like the exceptional personal compassion shown to residents and their family. They combine very competent technical professional care towards my [relative]". However, despite the positive feedback, we identified areas of practice that require improvement.

Quality assurance systems were in place to monitor the running and overall quality of the service and to identify any shortfalls and improvements necessary. Staff had conducted audits of areas including medication, health and safety, weights, blood pressures, accidents and incidents and infection control. However, the systems of quality assurance had not fully ensured that people received a consistent and good quality service that met individual needs. For example, people were placed at risk as the provider could not demonstrate that relevant training, including updates had been given to staff in a timely manner. Furthermore, at the last inspection on 28 September 2016, we saw that refresher training had not routinely gone ahead. It was felt at the time of the last inspection, that people were not placed at risk, however at this inspection the same issue has been identified. Additionally, the Provider Information Return (PIR) sent to us, which is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make, contained no information in respect to the training provided to staff.

People were placed at risk, as the provider did not have adequate systems and processes to enable them to fully assess and identify where quality and/or safety are being compromised and to respond appropriately and without delay. We have identified this as a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was not 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 and associated Regulations about how the service is run. The service had been without a registered manager for approximately five months. Day to day charge of the service was carried out by the acting manager, who was also registered to manage another service in the group. At the time of our inspection, we saw evidence that formal action had been taken to recruit a registered manager and the process was ongoing.

We discussed the culture and ethos of the service with people, the acting manager and staff. A relative told us, "What I have learnt over the past five months is that what matters is not the quality of the decoration, or how smart the furniture is, the only thing that matters is the human, quality of the staff caring for the patients that is something you cannot train for or buy. It is a gift that you rather have or don't have. It is a gift that all the staff we encountered here from the manager to the most junior all share to an exceptional degree. It is an ethos of love and compassion, motivated by deep faith. If I was facing death over the next three months, I will be more than happy to entrust my care personally to the manager, her deputy and their

staff". Another relative added, "Staff have been so friendly from the outset, very good professional approach with our best interests at heart". The acting manager said, "I lead by example and help staff all I can. We can add the skills, but you need to be compassionate. We are trying to mould people into a team and build a culture for staff. We are very skilled at looking after highly dependent people, knowing what they want, even when they can't communicate. We are very good at anticipating what they need. We make them feel safe and build trust". A member of staff added, "This is a good home. We give good care. Care that people want and need. We smile a lot". We saw a detailed mission statement and philosophy of care displayed for people and staff to read.

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. There was a suggestions box, and meetings and satisfaction surveys were carried out, providing the acting manager with a mechanism for monitoring satisfaction with the service provided. In respect to meetings, one person told us, "Yeah, I attend them". A relative added, "Sometimes I attend, because it happens late in the night". Feedback from the surveys was on the whole positive.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management including any issues in relation to equality, diversity and human rights. Management was visible within the service and the acting manager and deputy manager took an active approach. One member of staff told us, "I'm well supported. We welcome new staff. We are good colleagues, like a family". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff said, "[Acting manager] is a very approachable person and she thanks us for doing things well. There is good teamwork". Another member of staff added, "We support each other and communicate well with the residents and staff".

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice.

Up to date sector specific information was made available for staff, including guidance around the Mental Capacity Act 2005 and details of dementia care studies. We saw that the service also liaised regularly with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. Additionally, the service engaged with the local community and representatives from local churches visited the service to spend time with people.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured they had effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

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 staff were supported to undertake training, learning and development to enable them to fulfil the requirements of their role.