Rotherwood Healthcare (Lynhales Hall) Limited

Lynhales Hall Nursing Home

Inspection report

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28 September 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 28 September 2018. The first day of our inspection visit was unannounced.

Lynhales Hall Nursing Home 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.

Lynhales Hall is registered to provide nursing care and accommodation for a maximum of 73 older people. At the time of our inspection there were 43 people living at the home. The home is divided into two units. The 'main house' provides accommodation for up to 53 people. The 'John Sperry Unit' is a modern ground floor extension to the main building, which provides nursing care for up to 20 people living with dementia.

The registered manager had left the service a few days before our inspection, and the provider was in the process of recruiting their replacement. 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.

We were not assured staff always adhered to the provider's safeguarding procedures to ensure abuse concerns were reported and, where necessary, escalated without delay. Work practices in relation to the handling and administration of people's medicines needed to be improved to ensure they received their medicines safely and as prescribed. Infection prevention and control practices at the home were not as effective or robust as they needed to be. Staff training was not up-to-date and agency nurses had not always been inducted in line with the provider's expectations. People's rights under the MCA were not fully promoted by the provider.

The provider monitored and adjusted staffing levels to ensure there were enough staff to safely meet people's needs in a person-centred manner. The risks associated with people's individual care and support needs had been assessed, reviewed and plans implemented to manage these. The provider carried out pre-employment checks on prospective staff to ensure they were safe to work with people.

Prior to people moving into the home, an assessment of their individual care and support needs was completed to establish whether the service could meet these. The management team understood the need to avoid any form of discrimination through taking into account people's protected characteristics. People had support to choose their food and drinks and any physical assistance needed to eat and drink in comfort and safety. Any complex needs or risks associated with people's nutrition and hydration had been assessed and plans put in place to address these. Staff played a positive role in ensuring people's health needs were met, and sought prompt professional medical advice and treatment in the event they became unwell. The overall design and adaptation of the premises reflected people's needs, including those who were living

with dementia. Appropriate DoLS applications had been made and any conditions on granted authorisations were reviewed in order to comply with these.

Staff treated people in a kind and compassionate manner and had taken the time get to know people's individual needs, requirements and personalities well. People had support to express their wishes and participate in decision-making which affected them. People's rights to privacy and dignity were understood and promoted by staff and management.

The care and support provided reflected people's individual needs and requirements. People's care plans were individual to them, promoted a person-centred approach and included information about people's communication needs. People had support to participate in a range of social and recreational activities. A complaints procedure was in place to ensure complaints were dealt with fairly and consistently, and people and relatives knew how to raise concerns with the provider. Systems and procedures were in place to identify and address people's preferences and choices for their end-of-life care.

The provider's governance systems needed to be further improved to enable to them more effectively monitor aspects of the service in which we identified shortfalls in quality, and to ensure accurate and complete records were consistently maintained in relation to people's care and support. People and their relatives described open communication with an accessible and approachable management team. Community health and social care professionals had effective working relationships with a management team who were willing to take on board their recommendations. Staff felt valued and well-supported by the management and clinical team as a whole. The provider took steps to involve people, their relatives and staff in the service through, for example, arranging meetings to consult with them. Efforts were made to maintain strong links with the local community to the benefit of people living at the home.

We found two 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?

Requires Improvement

The service was not always Safe.

We were not assured staff always followed the provider's safeguarding procedures.

The management of people's medicines needed to improve to ensure they received these safely and as prescribed.

Staffing levels ensured people's individual needs and requirements could be met safely.

Is the service effective?

Requires Improvement

The service was not always Effective.

Staff training was not up-to-date and agency nurses had not always been inducted in line with the provider's expectations.

People's rights under the Mental Capacity Act were not always fully promoted.

People had support to eat and drink and any associated risks were assessed, reviewed and managed.

Is the service caring?

Good

The service was Caring.

Staff adopted a caring approach towards their work and knew the people they supported well.

People's involvement in decision-making that affected them was encouraged by staff and management.

People were treated in a respectful and dignified manner.

Is the service responsive?

Good

The service was Responsive.

People's care and support reflected their individual needs and requirements.

People had support to pursue their interests and participate in a range of stimulating activities.

People and their relatives knew how to raise any concerns or complaints about the service provided.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The provider's quality assurance systems had not enabled them to address the shortfalls in quality we identified during our inspection.

People and their relatives felt able to bring issues or concerns to the attention on an approachable management team.

Staff felt well-supported and valued in their work.

Lynhales Hall Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection checked 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.

The inspection took place on 20 and 28 September 2018. The first day of the inspection visit was unannounced. The inspection team consisted of two inspectors, an Expert by Experience and a specialist advisor who is a nurse specialist. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for their views on the service.

During our inspection, we spoke with six people who used the service, five relatives, two friends of people living at the home, five community health and social care professionals, the operations manager, business and hospitality manager, deputy manager, clinical lead and two nurses. We also spoke with provider's administrator, an activities coordinator, one senior care staff member, four care staff and one member of the domestic staff team.

We looked at a range of documentation, including seven people's care and assessment records, medicines records, incident and accident reports, three staff recruitment records, staff training and induction records, complaints records, safeguarding records, certification related to the safety of the premises and records associated with the provider's quality assurance.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found further improvements were needed to ensure people were consistently protected from avoidable harm. The rating for this key question remains 'Requires Improvement'.

The provider had safeguarding procedures in place, designed to protect people from abuse or neglect, and ensure any witnessed or suspected abuse was reported to the appropriate external agencies and fully investigated. Our records showed the provider had previously made us aware of any abuse concerns involving people who lived at the home in line with these procedures. The staff we spoke with understood the different forms and potential indicators of abuse, and the need to remain alert to these. One member of staff explained, "If I thought someone was being abused, I would report it to a nurse. If that wasn't resolved appropriately, I would report it to management, or direct to safeguarding." However, we were not assured all staff fully understood and adhered to the provider's procedures for reporting abuse. During the inspection, two members of staff raised potential safeguarding concerns with us regarding people's care and support at the home. We immediately shared this information with the provider, who took prompt action to keep people safe, notified the relevant external agencies and commenced an internal investigation into these allegations. The operations manager acknowledged the staff in question had not reported and escalated these concerns, at the time they arose, in line with the provider's procedures. They assured us all staff would receive additional support to ensure they fully understood the provider's safeguarding procedures through one-to-one supervision meetings with a line manager.

At our last inspection, we found improvements were needed in the management of people's medicines. These related to the monitoring of medicine stock levels, procedures for giving people their medicines covertly, and a lack of staff guidance on the use of 'as required' (PRN) medicines. At this inspection, we found that, although some improvements had been made, further improvement was required to ensure people received their medicines safely and as prescribed. People's medicines held on site were stored securely and within a suitable temperature range. People received their medicines from trained nurses who maintained up-to-date medicines administration records (MARs) and had been provided with guidance on when to give people's PRN medicines. Medicines stock levels were monitored on an ongoing basis to prevent people from running out of their prescribed medicines. Any decisions taken to administer individuals' medicines covertly had been reached in consultation with people's GP, pharmacist and relatives, and clearly recorded.

However, handwritten entries on MARs were not always signed by two trained members of staff, to confirm their accuracy, in line with good practice. We also found a small number of medicines did not have a legible prescriber's label attached to them detailing for whom they had been dispensed, and how and when they were to be used. We did not identify anyone who had not received their medicines as prescribed as a result of this issue. In addition, the dates people's medicines were opened, and their calculated expiry date, had not always been recorded on medicines containers. We discussed these issues with the management team who assured us they would address these as a matter of priority. We will follow this up at our next inspection.

During our inspection, one person's relative expressed concern regarding the omission of one of their loved one's medicines in July 2018. The provider assured us this matter had been subject to an internal investigation.

We looked at how the provider protected people, staff and visitors from the risk of infections. Staff were provided with infection control training, and issued with 'flash cards' to remind them of good hand-washing practice and the expected use of personal protective equipment (PPE). The management team had introduced a targeted assessment tool, to help them monitor how well they were protecting people from the risk of infections.

However, we found infection prevention and control practices at the home needed to be improved. For example, the pressure-relieving mattresses and cushions we looked at had not been properly maintained and were no longer fit for purpose. The covers on this equipment had been become damaged or had developed leaks, resulting in staining on the interior of the mattresses and cushions. Damage of this nature can promote the growth of micro-organisms, which are a potential cause of transmission of infection. The personal protected equipment (PPE) supplied by the provider for staff use (i.e. disposable gloves and aprons) was not always stored correctly or used appropriately by staff, when, for example, supporting people to use the toilet. Correct use of PPE is an integral part of infection control and prevention measures that protect people, staff and visitors from body fluids and other infectious agents. In addition, staff informed us that hoist slings were being shared between people. This practice, again, increases the risk of cross infection. We discussed these concerns with the management team. They carried out an immediate audit of all the pressure-relieving mattresses and cushions in use, replacing any defective items. The management team also introduced a new audit tool, to enable them to better monitor the condition of pressure-relieving equipment moving forward, and assured us they would provide staff with additional support in this area. We will follow this up at our next inspection.

People told us they felt safe and well cared for at Lynhales Hall Nursing Home. One person said, "I am very well looked after here, and I feel safe and happy." Another person told us, "I can't remember much, but I know I am safe here and I know they [staff] are kind to me."

The provider had systems and procedures in place, designed to enable them to assess and review the risks associated with the people's individual care and support needs. This included an assessment of people's mobility needs and risk of falls, their vulnerability to pressure sores and their nutritional needs. Plans had been implemented to manage these risks, including, for example, the use of height adjustable beds, movement sensor mats and crash mats to protect people who were at increased risk of falls. The staff we spoke with showed good insight into the specific risks to individuals, and knew where to turn for guidance on how to support people safely. An agency worker told us, "They [provider] have this very good written handover sheet and a 'precautions and concerns' form giving you brief information about the residents." Staff 'handovers' took place on a daily basis to enable the nurses leaving duty to update staff arriving on shift about people's current care needs and any changes in risk. The management team maintained a 'risk register board' to assist them in monitoring the key risks to individuals. In the event people were involved in an accident or incident, staff understood how to report and records these events. We saw the management team monitored these reports, on an ongoing basis, to ensure lessons were learned and reduce the risk of things happening again.

People, relatives and staff were satisfied the staffing levels maintained at the home enabled people's needs to be met safely. One relative told us, "There always seem to be plenty of staff when I'm around." A staff member said, "At the moment, staffing levels are safe and the quality of care is good." The operations manager explained staffing levels were monitored and adjusted in line with people's dependency levels,

occupancy levels at the home, feedback from staff and observations undertaken by the management team. During our inspection visits, we saw there were enough staff on duty to respond to people's needs and requests, without unreasonable delay, and to ensure people were monitored to promote their safety and wellbeing.

The provider completed checks on prospective staff to ensure they were safe to work with people. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions. They also requested confirmation from the staffing agencies that agency staff had undergone appropriate checks.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found further improvement was needed. The rating for this key question remains 'Requires Improvement'.

At our last inspection, we found the approach adopted to staff induction and training was inconsistent. Staff reported differing experiences of the induction, training and they had received to help them succeed in their roles. At this inspection, people, their relatives and community professionals spoke positively about the overall competence of staff. One person explained, "I do get anxious and very depressed, and they [staff] always know what to do to cheer me up and make me feel better." One relative told us, "They [staff] seem to be very capable, and I've never seen them anything other than happy and relaxed." A health and social care professional said, "They [staff] have a good understanding of people's needs. They do seem very competent, and the nurses are very well informed."

The majority of the staff we spoke with described their induction experience and the ongoing training and support available to them positively. On the subject of their induction, one staff member explained, "They explained a lot; it was good. I was shadowed for a week … I knew where to go to enquire if I was concerned about anything." We saw the provider's induction programme took into account the requirements of the Care Certificate. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff. In relation to their ongoing training, a nurse told us, "I feel I have plenty of training for my role … I have supervision with the clinical lead. She is very supportive - as are the management team." A member of staff told us, "We definitely have enough training, which is mandatory." Another member of staff described the benefit of their training on adult nutrition, which helped them monitor and improve this aspect of people's care.

However, the staff training records we looked at pointed towards gaps in staff training, including safeguarding training, health and safety training and dementia awareness training. The operations manager acknowledged that the registered manager had not monitored and addressed staff training needs in line with the provider's expectations. They assured us a training plan would be developed to address any outstanding training as a matter of priority. Following our inspection visits, the provider informed us that the information recorded on the home's staff training matrix may not be fully accurate and up to date due to an administrative issue, which they were now addressing. In addition, we found agency nurses had not always been inducted in line with the provider's expectations. The operations manager had developed a home-specific induction plan for agency staff and nurses to ensure they had the information they needed to work safely and effectively. Due to miscommunication within the management team, agency nurses had not completed this induction, but rather a shorter induction checklist. The administrator took immediate action to rectify this issue. We will follow these issues up at our next inspection.

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.

We checked whether the service was working within the principles of the MCA. Staff received training on, and understood, people's rights under the MCA and what this meant for their work. We staff they sought people's permission before carrying out their routine care and respected people's choices. One staff member explained, "You must obtain consent for everything you do for that person." Do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions had been appropriately recorded in people's care files. Where people had appointed others to make decisions on their behalf, the management team had obtained proof of their lasting power of attorney (LPA).

Formal mental capacity assessments and associated best-interests decisions had been completed and documented in relation to significant decisions about people's care such as the administration of their medicines by staff, the use of bedrails, movement sensors and mobility equipment, and support with nutrition and hydration. However, we found people's rights under the MCA were not fully promoted. The decision to care for people in their beds had not always been made and documented in line with the requirements of the MCA. In addition, people's consent to photographs for medical purposes had not been consistently sought or associated best-interests decision-making recorded. The provider had a system in place to record people's consent to medical photographs, but the records of consent we looked at had not been completed. We discussed these issues with the provider, who assured us these would be addressed as a matter of priority. We will follow this up at our next inspection.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the management team had made applications for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, they had reviewed any associated conditions, in order to comply with these.

Before people moved into the home, the registered manager met with them, their relatives and the health and social care professionals involved in their care to assess their individual care and support needs and establish whether the service could meet these. Initial risk assessments and care plans were then completed whilst people's needs and requirements were further assessed following their admission. One person's relative raised concerns regarding their loved one's admission process and the extent to which risks had been effectively communicated and managed at the point of their admission to the home. We discussed these issues with the management team, who assured us procedures were in place to keep people safe from the outset of their care.

The management team recognised the need to avoid any form of discrimination, and take into account people's protected characteristics, in the planning and delivery of people's care. They liaised with a range of community health and social care professionals, including GPs, social workers, the community mental health team and specialist nurses to help them achieve positive outcomes for people and ensure they had access to the appropriate care equipment.

At our last inspection, people's relatives expressed mixed views about the standard of the food on offer at the home, and we saw the quality of the people's meals was variable. Since this time, the provider had brought in an external ready-made meal service, and employed a business and hospitality manager, part of whose role was to drive improvement in catering and people's mealtime experience. They had also appointed four 'nutrition champions' amongst the staff team to ensure people's individual dietary

requirements were being met, choice of food and drink was being fully promoted, and to obtain feedback from people on their mealtime experience. At this inspection, people and their relatives spoke positively about the choice of food and drink served at the home. One person told us, "The food is always very good here. I enjoy it all and we never have to wait." A relative described the food as 'wonderful', describing how staff encouraged their loved one, who had a reduced appetite, to eat.

We saw mealtimes were flexible and unrushed events, during which people chatted with one another and received any physical assistance to eat safely and comfortably. One relative explained, "[Person] won't eat in the dining room, so they [staff] bring them their meal and pudding in their bedroom. It's like there are waiting on them!" Staff supported people to choose between the meal options available with patience, by physically showing them each meal plated up where necessary. We saw there was a good choice of food on offer, which looked and smelled appealing. Staff recognised the importance of keeping people well-nourished and hydrated, and supplied people with drinks and snacks between meals. One staff member explained, "We have really stepped up hydration recently. We push liquids more at meal times, and I ensure staff are doing this. It is working much better." People's individual dietary requirements and any specific risks associated with their eating and drinking had been assessed and recorded. Plans were in place to manage these, including the provision of texture-modified diets, thickened drinks, supplements prescribed by the GP and the monitoring of people's food and fluid intake. One person explained, "They [staff] do try to make my diabetic food as good as possible, so that I enjoy it. It is the sweet things I miss, but they try very hard for me as I hate having to diet."

People told us they saw their doctor whenever they needed to, and people's relatives were confident staff and management would seek prompt medical advice and treatment in response to any significant changes in their loved ones' health. One relative told us, "The GP is there every Tuesday and if there is a problem [in between these visits], they [staff] ring them up and they come out to the home." People's care files included information about their medical history and long-term health conditions to ensure staff understood this aspect of their care needs. Personalised care plans had been developed to explain staff's role in monitoring and managing people's long-term health conditions, such as diabetes, and their current health needs. One person told us, "I have an ulcer on my leg, but it is getting better. I had one on the other leg and they [nurses] sorted that out for me. They are very gentle when it is dressed; they don't hurt me. I am sure if they were worried, they would see the doctor who is very nice."

The overall design and adaptation of the premises ensured staff were able to meet people's individual needs safely and effectively. People had access to the home's grounds, and suitable space within the nursing home to participate in social activities, dine in comfort, meet with visitors or spend time alone. The premises had been adapted to create a dementia-friendly environment within the John Sperry unit. This has been achieved through, for example, the use of clear pictorial signage and installation of memory boxes outside bedrooms to help people orientate themselves. People also had access to wall-mounted activity boards and a range of other sensory and memory resources.

Good

Is the service caring?

Our findings

At our last inspection in August 2017, we rated this key question as 'Good'. At this inspection, we found people continued to be treated with kindness, dignity and respect. The rating for this this key question remains 'Good'.

People and their relatives told us staff treated people in a kind and compassionate manner. One person explained, "All of the staff here are very kind to me and the rest of us; they really do care about us." Another person said, "I cannot tell you how kind and caring they [staff] are to me here; nothing is ever too much trouble for anyone." A relative told us, "They [staff] are cheerful, helpful and really brilliant."

We saw people were at ease in the presence of staff and management, who they freely engaged in conversation and approached for any assistance needed. Staff knew the people they supported well, enabling them, for example, to enquire how specific members of their families were and when they were next due to visit. A community health and social care professional told us, "Care staff are always extremely pleasant, know the residents there well and can give you good information." Staff were attentive to people's needs and requests for assistance, and showed concern for people's safety and wellbeing. For example, when one person appeared unwell, a nurse carried out initial observations and arranged for them to be visited by a local GP that day. When another person became unsettled, staff were quick to respond with comforting words and touch, which helped to reassure the individual. Staff took the time to check whether people were comfortable or needed any help at regular intervals.

People and their relatives were satisfied with the support staff and management gave people to express their wishes and be involved in decisions which affected them. We saw staff respected people's preferences and choices in carrying out their routine care, including how they wished to spend their time, where they wanted to go and what they preferred to eat and drink. People's care plans included information about their individual communication needs, and provided staff with guidance on how to promote effective communication with each individual. The management team supported people to access independent advocacy services, where appropriate, to ensure their views were heard on important matters which affected them.

People and their relatives told us staff treated people with dignity and respect. One relative explained, "They [staff] all speak to [person] nicely and there is no rough treatment." We saw staff greeted people warmly and complimented them on their appearance upon seeing them for the first time that day. They spoke to people in a polite, professional manner and adhered to the provider's procedures for protecting people's personal information. Where people needed support to protect their modesty, we saw staff provided this in a prompt and sensitive manner. The staff we spoke with understood the importance of promoting people's rights to privacy and dignity, and were able to describe how they put this into practice in their day-to-day work. One staff member explained, "We are very conscious of, and actively promote, dignity and respect by closing doors and curtains and making sure people are covered up … There is so much you can do to encourage independence. We try as much as we can and involve them in activities and encourage them to feed themselves." Another staff member told us, "It is so important to treat people as you would

want to be treated and we are trying so hard to do that. After all, my relative could need to come here, and that's what I always try to remember. I love my job."

Good

Is the service responsive?

Our findings

At our last inspection in August 2017, we rated this key question as 'Good'. At this inspection, we found the service continued to meet people's individual needs. The rating for this this key question remains 'Good'.

Most people's relatives told us the care and support provided reflected their loved ones' needs and they felt involved in decision-making about the service provided. One relative told us, "We had a review in April … We also have informal chats about things [with staff and management]." The operations manager explained review meetings, or less formal discussions, were arranged with people's relatives in response to any significant changes in needs.

People's care plans reflected an individualised assessment of their care and support needs. They provided staff with clear guidance on how to care for people safely and effectively, and included details of their personal backgrounds and known preferences to encourage a person-centred approach. The provider had recently made improvements to their care planning system to support the development of more personalised care plans. Staff recognised the need to consider people's protected characteristics when delivering their day-to-day care and support. One staff member explained, "I have just done a course in diversity and equality, which I found very useful. I think the home is good at promoting such issues." People's care plans included guidance on meeting people's communication and information needs, as required under the Accessible Information Standard. The Accessible Information Standard tells organisation what they need to do make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need.

People and their relatives spoke positively about the range of social and recreational activities on offer at the home, and the support people had to pursue their interests. One person told us, "There is always something going on or to do, and I like joining in. I am looking forward to the cats coming in later and I can't wait for the hairdresser to come in. I love having my hair done." Another person said, "I am cared for, fed, entertained and never lonely." The programme of daily activities provided included, led by the home's activities coordinators, included visiting musicians and singers, a gardening club, fun fitness sessions, massage, pet therapy, music therapy and tailored one-to-one activities.

People's relatives were clear how to raise a complaint about the service, but told us they had never had the need to do so. We saw people themselves were comfortable approaching staff with any issues or requests. One relative explained, "I could speak to the managers, the clinical lead or one of the staff in the office." The provider had a complaints procedure in place to ensure complaints were dealt with fairly and consistently. We looked at the most recent complaints received by the service and saw these had been handled in line with this procedure.

The provider had systems and procedures in place to identify people's preferences and choices for their end-of-life care. At the time of our inspection, one person was receiving palliative care and appropriate care planning was in place to ensure their needs and wishes were met. Nursing staff liaised with people's GP with regards to the prescribing of anticipatory medicines to improve their end of life care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in August 2017 we rated this key question as 'Requires Improvement'. At this inspection, we found the provider needed to make further improvements. The rating for this key question remains 'Requires Improvement'.

During our inspection visits, we met with the operations manager who was temporarily overseeing the day-to-day management of the service, supported by the business and hospitality manager, deputy manager and clinical lead. The registered manager had left the service shortly before our inspection, and the provider was in the process of recruiting a new manager. The operations manager had a good understanding of the duties and responsibilities associated with the provider's registration with CQC, including the need to notify us about certain incidents involving the people who live at the home. Our records showed the provider had submitted these 'statutory notifications' in accordance with their registration with us.

The provider had quality assurance systems and processes in place designed to enable them to assess, monitor and improve the quality of the care and support people received. These included medication audits by the provider's medication management lead, monthly domestic audits by the business and hospitality manager, and the completion of a monthly monitoring report by the registered manager. The latter report enabled the provider to monitor whether other in-house audits and checks were being consistently completed. These quality assurance activities informed the provider's monthly senior management meetings, enabling them to review trends, developments and changes in risk at the home. However, we found the provider's governance systems and processes were not as effective as they needed to be. This was the service's fourth successive overall rating of 'requires improvement', and the provider's quality assurance activities had not enabled them to address the shortfalls in quality we identified during our inspection visits. These included our concerns in relation to the management of people's medicines, and infection prevention and control practices at the home. In addition, improvement was needed in the standard of record-keeping to ensure accurate and complete records were consistently maintained in relation to people's care and support at the home. For example, we found one person's care plans did not refer to the treatment of their current chest infection and contained out-of-date information regarding the application of topical medicines. Another person's care plans lacked importance information about how they were supported to reposition themselves to reduce the risk of pressure sores.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's governance systems and processes were not as effective as they needed to be.

People and their relatives spoke positively about the overall standard of the care provided at the home and their dealings with the management team. One relative told us, "At the moment, I'm quite happy with [person's] care. They [provider] seem to do a grand job." Another relative said, "The staff are brilliant and they do everything they can for [person's name]." A further relative explained, "It's like a big family, and we know everyone there." People and their relatives told us the management team were accessible and approachable. We saw they maintained a visible presence around the home, and that people knew them by name.

Community health and social care professionals described effective working relationships with the management team, which promoted a joined-up approach to people's care. They told us management were receptive to, and acted upon, their recommendations, and spoke particularly highly of their dealings with the clinical lead. One health and social care professional told us, "[Clinical lead] is very open to suggestions, easy-going, competent and caring. She is also supportive of other staff."

Staff spoke about people's care and support with enthusiasm and described a strong sense of teamwork within the home. One staff member told us, "They [staff] are a good team. I enjoy coming to work here." Another staff member said, "I love the residents and I treat them like my family." Staff felt valued and supported by the management and clinical team, spoke positively about the temporary management arrangements and expressed confidence further improvements in the service would follow. One staff member told us, "[Operations manager] will listen and take action on things. She will tell you nicely if she doesn't like something … I feel more relaxed now and confident it's going to be fine." Another staff member said, "[Clinical lead] is a good source of 24-hour support. When I have any clinical or management queries, I go to her." Staff understood the role of whistleblowing, and felt able to challenge any practices or decisions taken by the provider which they disagreed with.

The provider took steps to involve people, their relatives and staff in the service. They achieved this through, amongst other things, organising relatives' meetings and staff meetings, which the operations manager indicated would be organised on a more frequent basis moving forward. Feedback questionnaires were also distributed to people and their relatives on an annual basis, and the resulting feedback analysed by the provider. The provider also produced a monthly newsletter to keep relatives and visitors updated on changes, events and upcoming activities at the home. The management team and staff recognised the importance of maintaining strong links with the local community to the benefit of people living at the home. The operations manager explained they responded to invitations to local events, such as tea dances, supported people to access local services and facilities, and invited local charities, interest groups and entertainers into the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems and processes were not as effective as they needed to be.