Mr & Mrs GT Lee

Gosberton House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Gosberton House Care Home is registered to provide accommodation and support for up to 46 people, including older people and people with a physical disability. There were 44 people living in the home on the first day of our inspection.

The registered provider also provides day care in the same building as the care home. This type of service is not regulated by the Care Quality Commission (CQC).

People's experience of using this service:
The provider was failing to provide people with consistently safe, effective, caring, responsive or well-led care.

The provider had failed to organise staffing resources safely and effectively to meet people's needs and preferences. The management of people's medicines was not consistently safe.

Some people's care plans and individual risk assessments were out of date. Records indicated that staff sometimes failed to meet the requirements of people's care plans, in areas including nutrition and skin care. Staff did not always follow current best practice guidance in their delivery of care. The provider's approach to quality monitoring was not consistently effective.

Some staff used institutional, impersonal language to refer to people living in the home. The provider had failed to maintain confidentiality in respect of people's personal information. There was limited evidence to indicate people who stayed in bed or in their room were provided with sufficient stimulation.

In other areas, the provider was meeting people's needs.

Staff worked collaboratively with local health and social care services to ensure people had support when required. Systems were in place to ensure effective infection prevention and control. Staff were provided with regular training and supervision. Staff recruitment practice was safe.

Staff worked in a non-discriminatory way and promoted people's independence. Staff worked in a generally person-centred way, responding to people's individual needs and preferences. People felt safe living in the home. Staff knew how to recognise and report any concerns to keep people safe from harm.

Staff were aware of people's rights under the Mental Capacity Act 2005 and supported people to have maximum choice and control of their lives, in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

The registered manager and acting manager provided strong, supportive leadership. The owners of the

home visited regularly and were well-known to people, their relatives and staff. The provider notified CQC and other organisations of issues as required. There was learning from significant incidents and any complaints were managed in line with the provider's policy. The provider was committed to the continuous improvement of the service in the future.

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

Rating at last inspection:
The last rating for this service was Good (published 1 June 2017). At this inspection we found a deterioration in the quality of the service. The rating is now Requires Improvement and the provider is in breach of regulations.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
We have identified two breaches of regulations reflecting the provider's failure to monitor service quality effectively and failure to organise staffing resources safely and effectively.

Please see the action we have told the provider to take at the end of this report.

Follow up:
We have requested an action plan from the provider to address the breaches of regulations identified at this inspection. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Gosberton House Care Home

Detailed findings

Background to this inspection

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

Inspection team:
Our inspection was conducted by an inspector, a specialist adviser whose specialism is nursing and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Two weeks before our inspection the registered manager had started her maternity leave. To cover her absence, the registered manager's deputy had taken on the role of acting manager. On the second day of our inspection, the registered manager came in to meet with our inspector and contribute to the inspection process.

Notice of inspection:
This inspection was unannounced.

What we did:
In planning our inspection, we reviewed information we had received about the service since the last

inspection. This included information shared with us by other agencies and any notifications (events which happened in the service that the provider is required to tell us about).

During our inspection we spoke with nine people to ask about their experience of the care provided. We also spoke with three family members, one of the cooks, two care staff, a nurse, the acting manager, the registered manager and a visiting healthcare professional.

We reviewed a range of written records including six people's care plans, two staff recruitment files and information relating to staff training and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

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

Staffing and recruitment

• Some people expressed their dissatisfaction with the provider's organisation of care staffing resources. For example, one person said, "They are often short in the evenings when we are getting ready for bed and I need … staff to take me to the toilet." Another person's relative told us, "I don't think there are enough staff. I find that my relative often has to wait to go to the toilet and that upsets her." On the first day of our inspection, one person told us that they had decided not to get up that day, as care staff did not come to provide them with assistance until 12 noon. The person told us that they liked to go back to bed in the middle of the afternoon and it was not worth getting up for such a short time.

• Staff expressed similar concerns. For example, one member of the care team said, "There's not always enough staff. There is supposed to be three [in each area of the home] in the morning. But it doesn't always happen [and] we have to rush [and] people have to wait a bit longer."

• We reviewed the results of the provider's 'Staff Questionnaire' conducted in May 2019 and noted that staff had expressed the need for more nurses. During our inspection, staff expressed their continuing concerns about the nurses' workload and the impact this had on the safety of people's care. For example, one staff member told us, "I mentioned [to a nurse] that [one person] had a couple of dressings that needed done [as they had] faeces underneath. She said, 'I haven't got time. You will need to get me when I am less busy.'." Similarly, in records relating to a recent incident, we found a person had been left in a soiled incontinence pad for almost an hour due to a delay in a nurse coming to undertake a procedure that had to be completed before care staff could change the pad. The person had been assessed as being at very high risk of skin damage and, at the time of the incident it was noted that their 'sacral area was very red and sore'.

• People also told us care staff did not always have time to meet their need for social interaction. For example, one person said, "It's hard for them. They come and chat when they can, but they are busy." A staff member told us, "[Once we have assisted people to get up] we have laundry to put away, pad changes and repositions. Then lunch [before] it starts all over again." We don't always get the chance to spend time with residents. They miss out."

• Senior staff monitored staffing levels on a regular basis, taking into account the needs of the people living in the home at that time. However, in the light of the concerns we identified on our inspection, further action was required to improve the organisation of nursing and care staffing resources, to ensure people received safe, effective and responsive care at all times. This was a breach of Regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager told us she was highly selective in the recruitment of new staff. Describing her approach, she said, "I am not the type who gives a job to anyone. In the last 12 months, of 460 candidates,

only five or six made it through." We reviewed recent recruitment decisions and saw that the necessary pre-employment checks had been carried out to ensure staff were suitable to work with the people who lived in the home.

Assessing risk, safety monitoring and management
• The provider maintained systems to ensure potential risks to people's safety had been considered and assessed. However, some risk assessments were out of date, increasing the risk of unsafe care. For example, the monthly review of one person's falls and moving and handling risk assessments had not been completed since June 2019, despite the provider's online care planning system indicating they were overdue.
• Some people had been assessed as being at risk of developing pressure ulcers and needed staff assistance to change position at specified intervals to help reduce this risk. However, the records maintained by staff indicated people were not being supported to reposition as frequently as specified, increasing the risk of skin damage. One person who had a pressure ulcer told us that staff did not always reposition them regularly and the care records we checked confirmed this.

Using medicines safely
• We reviewed the arrangements for the storage, administration and disposal of people's medicines and found these were generally managed safely in line with good practice and national guidance. Staff received regular medicines training and competency checks were conducted to ensure their practice remained up to date. Protocols were in place for any 'as required' medicines to provide staff with additional information about each medicine, to ensure they were administered safely and consistently.
• However, on the first day of our inspection we found tubs of prescribed fluid thickening powder which had been left out in open bedrooms. The acting manager told us she was aware of an NHS patient safety alert issued in February 2015 in response to the death of a care home resident who had ingested fluid thickening powder. This alert instructed 'all providers of NHS funded care where thickening agents are prescribed, dispensed or administered' to ensure arrangements were in place to ensure appropriate storage by 19 March 2015. Despite management awareness of this directive, the provider had failed to ensure appropriate storage arrangements, increasing the risk of potential harm. On the second day of our inspection, the acting manager told us that the fluid thickening powder was now stored securely in the same way as other prescribed medicines.
• Action was also required to ensure staff maintained an accurate record of any prescription creams they administered.

Preventing and controlling infection
•The provider had effective systems of infection prevention and control. For example, protective aprons and gloves were stored in various locations around the home to make it easy for staff to access them as required. Commenting on the cleanliness of the home, a relative told us, "[Name]'s room is always kept nice and clean and well-cared for."
• Staff had received training in this area and we observed this was reflected in their practice. For example, one of the cooks, quite rightly, instructed our inspector to wash his hands before he was allowed into the kitchen.

Systems and processes to safeguard people from the risk of abuse
• The provider had a range of measures in place to help safeguard people from the risk of abuse. For instance, staff had received training in safeguarding procedures and were aware of how to report any concerns relating to people's welfare. One person told us, "I do feel safe, as everyone is really friendly which adds to the atmosphere of trust."

Learning lessons when things go wrong

• The provider reviewed significant issues and events to identify organisational learning for the future. For instance, in response to a recent complaint, action had been taken to strengthen admission procedures.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
• The provider had procedures in place to identify people who were at risk of weight loss. However, these were not implemented consistently, increasing the risk to people's health and welfare. For example, one person had been assessed as being at risk of losing weight but staff had not developed a nutrition care plan to address this. Additionally, this person's eating and drinking risk assessment had not been updated since July 2019, despite a significant deterioration in the person's health during this time.
• Other people did have a nutrition care plan in place. However, the care records maintained by staff indicated some of these people had only been weighed monthly, rather than the weekly frequency stipulated in their care plan. Another person had been assessed as being at risk of weight loss and staff used a chart to monitor their food and fluid intake. However, there were significant recording gaps on the chart, which meant it was not possible to ascertain if staff were taking active steps to support the person to eat and drink enough.
• More positively, people told us they enjoyed the food and drink provided in the home and that their individual needs and preferences were met. One person told us, "The food is really very good." Another person said, "The staff keep an eye on me as I am a diabetic. They watch my blood sugars and if they go low they give me a drink and a banana."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Systems were in place to assess and determine people's individual needs and preferences. These were set out in each person's care plan. However, as described elsewhere in this report, the interventions set out in people's care plans and individual risk assessments were not always implemented consistently by staff, increasing the risk of people receiving ineffective, unsafe care.
• The provider used a variety of online and other information sources to help staff keep up to date with changes to best practice guidance and legislation. However, care practice did not always reflect current guidance, indicating the provider's approach in this area was not consistently effective.
• For example, for some people who had wounds, including pressure ulcers, nursing staff assessed the wound each time they changed a dressing. As part of the assessment, the nursing staff sometimes took a photograph of the wound. However, they did not measure the wound and the photographs were unclear. This failure to observe best practice in wound care limited the value of the assessment and increased risks to people's health.
• Additionally, on the first day of our inspection, we noticed a trolley laid out with personal protective

clothing including face masks. The acting manager told us several people had chest infections and the face masks had been provided for staff to wear when providing these people with personal care. She went on to say that some staff had shown flu or cold-like symptoms themselves and that the face masks were "mandatory" for them. However this practice was contrary to guidance issued in 2018 by Public Health England on the management of outbreaks of influenza and other respiratory infections in care homes. This states that, in managing any outbreak of this type, rather than being provided with face masks, staff presenting with symptoms of respiratory illness should be excluded from work until they have recovered.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA), provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• As part of our inspection we checked whether the service was working within the principles of the MCA. We were satisfied that appropriate legal authority had been obtained in situations where it was necessary to deprive people of their liberty. Additionally, senior staff made use of best interests decision-making processes to support people who had lost capacity to make significant decisions for themselves. These were documented correctly in people's care records.

Staff support: induction, training, skills and experience
• The provider maintained a regular programme of staff training. Commenting positively on the provider's approach in this area, one staff member told us, "I have recently done safeguarding, health and safety, moving and handling and infection control training. I have had all the training I need [and we have] annual refreshers. It's taken seriously." Another member of staff said, "They've asked me if I want to do NVQ Level 3. It's not for me at the moment, but I know the offer is there."
• New recruits participated in a structured induction programme which included a period of shadowing experienced colleagues before they started working on their own. New staff also undertook the national Care Certificate which sets out common induction standards for social care staff.
• Staff told us that they felt well supported by the management team. Talking of the registered manager, one staff member said, "[Name] is very supportive. She is always there if you need her." Staff received supervision and an annual appraisal from senior staff.

Staff working with other agencies to provide consistent, effective, timely care
• Senior staff had established effective working relationships with a range of external organisations to support them in the provision of effective care and support. To further enhance communication with local healthcare providers, the registered manager was in the process of applying for an NHS email address to enable people's confidential medical information to be shared securely when required.

Supporting people to live healthier lives, access healthcare services and support
• Staff worked proactively with GPs, district nurses and other health and social care professionals to ensure people had prompt access to local health and social care services when necessary. A local healthcare professional, who was visiting the home on the first day of our inspection, commented positively on the collaborative approach of staff.
• One person told us, "The GP comes into the home on a Wednesday and sometimes I have asked to see him for a routine issue. And I know the staff will always call a doctor or nurse if I need one [at other times]." Another person said, "An optician visited a few weeks ago and new glasses have been arranged for me. It is

good that the home arranges for us all to be checked out."
• Details of each person's oral care requirements were set out in their care plan. Staff received initial training in this area as part of their induction and had access to best practice guidance. Looking ahead, the acting manager told us she would look into organising regular oral care refresher training for all care staff.

Adapting service, design, decoration to meet people's needs
• The provider was committed to the ongoing maintenance and improvement of the physical environment and equipment in the home. For example, since our last inspection an accessible footpath had been laid, to enable more people to enjoy the garden. The provider had also installed raised beds in one of the courtyard gardens which people had used to grow strawberries.
• Shortly before our inspection, the provider had completed a refurbishment of the hairdressing salon. Reflecting the provider's wish to increase community links, the new salon had been advertised in the village to give local people the opportunity to use it.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people were not always treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; respecting equality and diversity
• The provider's website stated, 'Respect for the privacy and dignity of our residents is at the heart of everything we do at Gosberton House and is something all of our staff fully subscribe to.'
• However, despite this clear commitment to respecting people's dignity, during our inspection we heard staff describing the people who lived in the home in very insensitive, institutional terms. For example, between themselves, some staff called people who had specific nutritional needs, 'purees' or 'softs'. Commenting on the language used by some of their colleagues, one staff member told us, "They talk about 'doubles' and 'purees'. I have also heard 'softs'. It's very impersonal." Acknowledging the need for improvement in this area, the registered manager told us, "This [issue of] terminology is annoying for me. I have seen it myself and have tried to [eliminate it]. But some staff have a very deep-seated mind-set."
• The provider had also failed to uphold people's right to privacy in respect of their personal information. In a communal corridor there was a care station in an open bay with no door. This was often left unattended by staff and on the first day of our inspection, we found staff handover notes on a shelf near the entrance to the care station. This meant they could easily have been read by anyone passing in the corridor. One entry stated, '[Name]. Large BO. 10/19.' We confirmed that 'BO' stood for bowel opening. Similarly, there was a white board on the wall with details of people's dietary regime and when they were to be weighed.
• More positively, people told us that staff encouraged them to retain their independence for as long as possible. For example, one person said, "I can eat my meals on my own. As long as staff cut my food up for me, which they always do." A staff member told us, "It's always good to give people autonomy [where possible]. If I was to do [everything] for them, they would lose it."
• Staff were also aware of the importance of supporting people in a non-discriminatory way which reflected their beliefs and cultural preferences. For example, arrangements had been made for a Catholic priest to visit one person who had requested this spiritual support. Similarly, another person's religious belief about a particular medical intervention was highlighted in the information sheet to be used should they ever need to be admitted to hospital.

Ensuring people are well treated and supported; Supporting people to express their views and be involved in making decisions about their care
• People told us that staff were caring and compassionate. For example, one person said, "I am lucky to be here. The staff are kind and caring." Another person told us, "The staff are kind and friendly and … make me feel comfortable." On their birthday, the provider ensured people received a card, a cake and a gift.
• Staff were aware of the importance of supporting people in a person-centred way. One staff member said,

"Everybody is different. For instance, one lady doesn't like her [bedroom] door shut. [And] people have good days and bad days. We've got to be flexible." Describing how they had gone 'the extra mile' to meet one person's wishes, another member of staff told us, "Just recently [name] asked me if there was any chance of going to the pub when I was free. So I took [them] after work, in my own time. They had a whisky and loved every minute of it. I have arranged to do it again before Christmas."

• Most people told us that staff encouraged them to express their views and make their own decisions. For example, one person said, "I choose to stay in my own room as I prefer the privacy. But I could go to the lounge or dining room if I wanted to." Another person told us, "There is a good variety of food on offer. We are given two choices at lunchtime [and] and you can have something else if you [prefer]."

• Senior staff supported people to access the support of local lay advocacy services whenever this was required or requested. Lay advocacy services are independent of the provider and the local authority and can support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant there was inconsistency in the planning and delivery of people's care.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Since our last inspection, the provider had completed the implementation of an online system to plan and monitor the delivery of people's care and support. Talking enthusiastically about this initiative, one staff member told us, "I think it works much better [than paper-based systems]. They gave us phones [on which] we can see [details of people's care plan] and input progress notes." A relative said, "I have a copy of [name]'s care plan. We review it every three months with a member of staff. It is very comprehensive."
• However, despite this positive feedback, we identified a number of shortfalls in the provider's approach to care planning. For example, as detailed in the Safe and Effective sections of this report, individual risk assessments in areas including nutrition and falls were overdue for review, increasing the risk of unsafe or ineffective care.
• Additionally, some care plans lacked important information. For example, one person's continence care plan stated they had a urinary catheter and required bladder irrigation. However, it did not specify how frequently this should be done. Acknowledging the provider's failure to maintain the care planning system effectively, the acting manager told us, "Some of the care plans are a bit behind. We hope to catch up as soon as possible."
• Care staff told us they did not normally have time to look at people's full care plans as they were only available on laptop computers. However, they could view a summary of each person's care plan on their phone. When completed correctly, this summary provided a holistic profile of the person, which staff said they found helpful in promoting the provision of responsive, person-centred care.
• However, in some of the care plans we reviewed the summary focused on the person's current medical status and provided staff with almost no information about the person's life history or their likes and dislikes. For instance, the introductory 'My Key Messages' section of one person's summary care plan stated, 'I suffer from…' followed by a long list of the person's various illnesses and medical conditions. Similarly, the 'What Matters and What's Important to Me (preferences, likes dislikes and hobbies) section started, 'I suffer from ….', followed by a detailed description of the person's skin care regime.
•Despite these shortfalls in the provider's approach to care planning, some people told us staff were responsive to their individual needs and preferences. For example, one person said, "The staff know me well and always seem to understand what I need." At lunchtime on the first day of inspection we observed one person tell a member of staff that they did not want either of the main course menu options and requested porridge instead. The staff member brought the person some porridge, which they ate. Talking of one person who chose to spend most of their time in their room, the registered manager said, "[Name] loves

watching birds. So we have installed a camera [trained on] a bird feeder [in the garden], so they can watch [the birds feeding] on their TV screen."

Meeting people's communication needs
Since 2016 onwards, all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• The acting manager was unaware of the AIS but told us she would ensure the provider embraced it for the future.
• In the meantime, staff were aware of people's individual communication needs and preferences and reflected this in their practice. For example, staff used a spelling board and picture cards to communicate with one person who found it difficult to speak.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The provider employed three activities coordinators who, between them, worked 80 hours each week, normally Monday to Friday. The activities coordinators organised a programme of daily activities and events to provide people with physical and mental stimulation. For October 2019, these included keep fit, Scrabble club, quizzes, word games, baking and a visit from a professional entertainer.
• On the first day of our inspection, people had the opportunity to play board games in the morning and participate in a game of 'Who Am I?' in the afternoon.
• Most people we spoke with told us they enjoyed the programme of activities provided in the home. One person said, "We play dominoes, cards and bingo. We also have lots of sing-a-longs which are lovely." Another person commented, "I enjoyed the games this morning. We had a lot of fun." However, one person expressed disappointment at the lack of outings and another person who spent most of their time in their bedroom told us, "I never do anything. I have been asked only once or twice if I would like to get out of bed. It makes me feel bored and depressed."
• Reflecting this feedback, we reviewed the care records of two people who spent most of their time in bed or in their room. In the month preceding our inspection, each person's care record indicated that they had attended only two communal activities and had declined to attend one other.
• We talked with the registered manager about the provision of stimulation to people who spent most of their time in their room or in bed. She told us that the activities coordinators conducted regular 'room visits' to people in this situation, to provide "45 minutes just for you". However, care records we reviewed contained almost no evidence of any room visits, other than when one of the activities coordinators had dropped off the 'Daily Sparkle', a national newspaper produced especially for people living in care homes.
• We reviewed the results of the provider's staff survey conducted in May 2019 and noted staff had taken this opportunity to highlight the need for more activities for 'bed bound residents'.

Improving care quality in response to complaints or concerns
• People and their relatives told us they would contact senior staff if they had any queries or concerns. For example, one person said, "I complained that I did not like having male carers looking after me and the manager has made sure that I have not had a male carer since."
• The provider maintained a record of any formal complaints that had been received and we saw that these had been investigated properly in accordance with the provider's policy.

End of life care and support
• Staff provided responsive palliative and end of life care whenever this was necessary. People's end of life wishes and preferences were set out in their care record and senior staff attended a regular palliative care

forum to help keep their practice up to date.
• Commenting on the provider's approach in this area, the registered manager told us, "I am proud of it. We are complimented a lot by families." Reflecting this comment, following the recent death of a loved one, a relative had written to the staff team to say, '[Name] told me that … you were all wonderful and [that she] was very grateful for the care and kindness that you all showed her. Every one of you did an amazing job for my mum and family. So, a huge thank you … I know that she is no longer with us, but I am sure she sends you all one of those lovely smiles of hers. Thank you."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

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

• The registered manager had been in post since May 2017. Under her leadership, there had been a significant turnover in staff and considerable changes to procedures and practice. Most people we spoke with were supportive of the registered manager's approach and the changes she had made. For example, a relative told us, "The new manager came in with a lot of new ideas which I don't think a lot of the staff liked … resulting in a high turnover. The home has definitely picked up now." A member of staff told us, "[Name] is a really good manager. She can be strict [but] you need someone quite firm sometimes. I've seen a lot of changes … [for the] better. It's going really well."

• Under the leadership of the registered manager, the provider had reviewed and expanded the systems used to monitor and improve the quality of the service. For example, senior staff now monitored the number of urinary tract infections, pressure ulcers and hospital admission using a new 'key performance indicator' tracking system.

• However, as detailed throughout this report, the provider's approach to monitoring and improving service quality was not consistently effective. For example, senior staff knew that some people's care plans and individual risk assessments were out of date, but had not yet taken action to address this. The registered manager was aware of the use of insensitive, institutional language to describe people living in the home but had failed to take effective action to eradicate it. Similarly, the assistant manager was aware of an NHS directive on the safe storage of fluid thickening powder but had failed to implement it.

•The provider reviewed staffing levels on a regular basis but had failed to ensure the safe organisation of nursing and care staffing resources to meet people's needs and preferences. Months before our inspection, staff had raised concerns about the amount of stimulation provided to some people, but the provider had not taken effective action to address this.

•Further improvement to the provider's approach to service monitoring and improvement was required, to ensure the provision of a consistently safe, effective, responsive and caring service. This shortfall in organisational governance was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• More positively, people told us that they thought the home was generally well-managed. For example, one person said, "The home seems to run pretty well [although] the staff are busy." Another person's relative told us, "The home seems pretty good."

• Shortly before our inspection, the registered manager had gone on maternity leave and her deputy had

taken on the role of acting manager. Although she had only been in post for a short period of time, the acting manager had gained the confidence of her team. For example, one staff member told us, "I am really happy with [name]so far. She has been really supportive. I am always able to come and chat to her."
• The provider ensured CQC and other agencies were notified of significant incidents or events.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
• Throughout our inspection, both the registered manager and the acting manager displayed an open, responsive leadership style. For example, during our inspection, the acting manager took prompt action to change the storage arrangements for the fluid thickening powder we found in people's bedrooms. Discussing the importance she placed on candour, the registered manager told us, "I am honest, I tell it how it is. Lies have little legs and will [always] be caught."
• The owners of the home visited regularly and were well-known to people, their relatives and staff. One staff member told us, "[Name of one of the owners] comes every six weeks and always, always talks to staff. He normally walks round the home and has a chat with everyone. He asks if we have any problems and [if we have] they are dealt with straightaway."
• The provider promoted the welfare and happiness of the staff team in a variety of ways. For example, the registered manager told us that staff received a card on their birthday and a gift hamper at Christmas. Regular 'awards ceremonies' were held to acknowledge and congratulate staff who had gained the Care Certificate, an NVQ or other qualification.
• Reflecting this caring approach, most staff told us there was a positive organisational culture in the home. For example, one staff member said, "We get on really well [and] are really supportive of each other."
• To promote people's involvement and engagement with the service, the provider produced a regular newsletter and hosted regular meetings with people and their relatives. Commenting positively on this approach, one relative told us, "I came to a relatives' meeting … and suggested a board be left in my relative's room for staff to leave messages for me. This was done."
• The provider also undertook an annual survey of people, their relatives and staff, to seek their views on the service. The feedback in the most recent surveys was generally positive. For example, one person had written, 'I love all the food given. Presentation very good.' The provider published the results of the surveys, together with any action taken in response.
• The provider was committed to the ongoing improvement of the service in the future. For example, the registered manager told us she intended to review staff handover arrangements, to facilitate more effective internal communication. She also told us of her plans to convert the home's garden summer house to a café that could be enjoyed by people and their relatives.
• As detailed in the Effective section of this report, the provider had established good relationships with a range of other organisations including local GPs and training providers. The provider was also committed to strengthening links with the local community, for example through the opening up of the refurbished hairdressing salon to local people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's approach to quality monitoring was ineffective in ensuring the provision of consistently safe, effective, caring and responsive care.

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 failed to organise staffing resources safely and effectively to meet people's needs and preferences.