# Highpoint Care (West Derby) Limited

# Damfield Gardens

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Inadequate** |
| 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

This inspection took place on 6 and 7 November 2018. The first day of inspection was unannounced.

Damfield Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Damfield Gardens opened in April 2018 and is a newly-built care home providing accommodation for up to 67 people. The service is laid out across three floors, with two floors dedicated to people living with advanced dementia. The service is situated in a residential area of Maghull, with nearby facilities including shops and public transport. At the time of the inspection, there were 51 people living at the home.

The service had a registered manager. A registered manager is a person who has registered with CQC 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.

This was our first inspection since the service registered with CQC in April 2018. The registered provider and registered manager were open and honest about the difficulties they had encountered, as well as the improvements they were aware needed to be made.

During this inspection we found breaches of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
You can see what actions we told the provider to take at the end of the full report.

People, relatives and professionals told us there were not always enough staff to meet people's needs and keep them safe. The service had identified staffing as a main difficulty themselves.

The knowledge and confidence of staff, including agency staff, to provide safe, person-centred and specialist care to people needed to be developed.

The management of people's medicines was not always effective, which meant some people did not receive their correct medicines or did not receive them on time. The provider was changing to a different medicines management to make it more effective.

Risk monitoring and assessment processes were not always effective to keep people safe. Aside from other injuries, four people had fallen and sustained fractures in less than three months. Quality processes and audits were not always effective at leading to improvements and ensuring safer, better quality care for people.

The service did not always meet people's individual needs.

Feedback from people using the service, their friends and families, staff and visiting professionals was mixed. We heard about things the service did very well, but equally about concerns. However, all those who had concerns agreed that they had confidence that, given time and support, the service would make the necessary improvements. We heard comments about a warm, caring and open culture that had developed and we observed this during our inspection.

Staff knew safeguarding procedures and had confidence managers would address any concerns. Safeguarding concerns were referred to the local authority, but the service's recording of these needed to be clearer.

Care files showed staff had completed risk assessments to assess and monitor people's health and safety. These had not always been reviewed following accidents and incidents to show what lessons had been learned.

Recruitment checks for permanent staff was robust. The service had not always received all relevant information about agency staff before they worked within the home.

Regular health and safety checks of the premises were in place. We discussed with the service checks that needed to take place more often, as well as improvement needs to the building.

We found the environment to be generally clean and bright. Staff were knowledgeable about good infection control practice.

The service was working with professionals to specialise the environment for people living with dementia and make it safer.

Where people could not consent to care and treatment, the use of appropriate assessments needed to improve. However, we also found good examples of working together in people's best interest. Appropriate applications to the local authority had been made.

The service was working with a variety of other health professionals to maintain people's wellbeing. This needed to be developed further through greater staff confidence and competence. Communication within the service and with others was not always effective.

Staff told us they felt well supported and could raise any issues with the registered manager.

People had enough to eat and staff supported them to choose from a variety of meals. At times, recording and support for people to have enough to drink needed to improve.

We observed staff interacting with people in a patient, supportive way. Overall, people and relatives told us staff were kind, caring, treated them with respect and made them feel welcome.

Relatives felt involved in the planning of their loved one's care, but involvement of people and their wishes needed to be developed.

People's care plans contained person-centred information, but needed to be more detailed and consistent to guide all staff more clearly and protect people.

Complaints were recorded appropriately, acted upon and responded to by the registered manager.

The service had recently employed an activities coordinator, but they were still developing the activities on offer to stimulate and engage people.

Team meetings, residents' and relatives' meetings took place regularly.

People, relatives and staff praised the registered manager and the provider for being open, available and supportive. We observed both being present around the service and engaging with everyone. We also noted the new manager had identified good development plans.

The registered manager had submitted relevant notifications to CQC, but we needed to clarify a few additional ones they needed to send in line with legal requirements.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Staffing needed to be more robust and consistent to meet people's needs and keep them safe.

The management of people's medicines was not always effective, so people did not always receive the correct medicine and at the right time.

The management of risk for people using the service was not always robust.

The service was clean during our visit. Aspects of the environment needed to be improved and made safer.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Communication within the service and with others was not always effective. Working with health professionals was improving.

People had enough to eat and were encouraged to choose from a variety of meals. The service at times needed to ensure they checked people drank enough.

The specialist aspects of the service needed to be developed through further training and review of the environment.

The service needed to develop their working within the principles of the Mental Capacity Act.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff we observed treated people with kindness and respect. We heard examples of staff going 'the extra mile' to ensure a caring service for people.

Aspects of the dignity in care for people needed to be improved, such as whether people were well presented.

Relatives and professionals we spoke with felt the caring culture the consistent staff were developing would help the service to improve.

People needed to be involved more clearly in the planning of their care.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not always detailed enough or up-to-date to guide staff.

People's individual needs were not always met.

The service was developing its activity offer. People and relatives felt this needed to improve.

People and relatives felt listened to. The registered manager recorded and responded to complaints appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Systems and records in place were not always operated effectively to promote the safety and quality of the care people received.

Resident, relatives and team meetings took place regularly.

People, staff and relatives praised the approachable nature of the registered manager and provider. We observed both engaging with everyone on the days of our visit.

The registered manager had submitted certain types of notifications to CQC, but not others. We clarified this.

# Damfield Gardens

**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.

This inspection took place on 6 and 7 November 2018 and was unannounced. The inspection team included three adult social care inspectors 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.

Before our inspection we reviewed information we held about the service. This included the statutory notifications sent to us by the registered provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

We also contacted the commissioners of the service and the local safeguarding team to gather their views. We used all of this information to plan how the inspection should be conducted.

We spoke with nine people who lived at the home, as well as nine of their family and friends. We also spoke with five visiting health professionals.

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.

During the inspection we also spoke with the owner, the registered manager, the home's new manager and a registered manager from another home who was supporting the service. We spoke with eight members of staff. This included senior staff members, care assistants, domestic and maintenance staff, as well as an activities coordinator.

We looked at the care files of five people receiving support from the service. We sampled four staff recruitment files, three agency worker profiles, as well as staff rosters for the four weeks leading up to our

inspection. We checked daily communications, people's care charts and records, as well as medicine administration records and audits. We also looked at the service's incident and accident forms, safeguarding records, regular safety and maintenance checks, quality assurance processes, as well as training and supervision information.

We walked around the home on both days of our inspection and observed the delivery of care at various points during the inspection.

Following our inspection, we received further information from the registered manager and a member of the public. We included this in our judgement, as it related to people's safety.

Inadequate

# Is the service safe?

## Our findings

There were not always enough staff to meet people's needs and keep them safe. Staff cover needed to be more consistent and robust. People using the service, relatives and professionals we spoke with told us this. We also saw this in the staff rosters we viewed for the previous month.

All of the people who lived at the service we spoke with felt there was not enough staff on duty, day or night. One person said, "There are not enough staff so they are run of their feet." Another said, "I sometimes have to wait a long time for my call bell to be answered, especially in the night." We heard from a relative that they did not always feel safe to leave their family member and at times had to help them to get to bed at night due to a shortage in staff.

We saw that the service used a "late" and "early" shift to add a member of staff when people needed more support. For example, the late shift included the time between 8pm and 10pm. This shift on two thirds of the days we looked at on rosters had not been covered. This meant that from 8pm until 8am ('the night shift') on most days there were six staff in the home looking after 51 people. This included the busier bedtimes and times when staff needed to hand out people's night-time medicines. On a couple of occasions, we found there were fewer than six staff on the night shift, according to the rosters.

The service relied on the use of agency staff to make up numbers while they continued to recruit permanent team members. We found that during the four weeks of rosters we viewed 42 shifts had been covered by 23 different agency staff. The service could not always evidence robust induction for agency staff to be able to work in a person-centred way to keep people safe.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager highlighted robust and consistent staffing as a difficulty to us and explained their plans on how to create greater stability.

The management of people's medicines was not always effective. This meant that people did not always receive their medicine correctly and on time. We found that one person had on several days since a change in their prescription not received their medicine. The service themselves had identified on two occasions that people's medicines had been signed for, but not actually given. On the first day of our visit, a morning medicines round did not finish until 12.30pm. We observed that although staff giving out medicines wore a tabard that stated, "Do not disturb", they frequently had to help out elsewhere. We understood the provider was introducing a new system in the week of our inspection.

The management of people's risk needed to be more robust and communicated more effectively. We saw that staff had completed different risk assessments for people and we observed that staff were knowledgeable about approaches to keep people safe. However, as the service often relied on staff members at short notice who did not have this knowledge, information about people's risks in their care

plans needed to be clearer. For example, four people had a fall resulting in a fracture in less than three months, between 20 August and 13 November 2018. Following a person using the service having two incidents involving other people living at the home on the same day, their care plans had not been updated. For a person whose specific health need required good monitoring and provision of fluids, charts did not evidence this had been done. This put the person at greater risk of infection.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were aware of safeguarding procedures. Staff told us they were confident that managers would address any concerns they had. A confidential whistle-blowing line was advertised in the staff room. Staff also told us they would be confident to whistle-blow to other organisations if needed, such as the local authority or CQC.

We saw that the service had referred safeguarding concerns to the local authority. The recording of relevant information from accidents, incidents and the lessons learned needed to be clearer at times. We saw the service kept overviews of people's incidents and accidents, including a floor plan mapping out where falls had occurred. However, it was not always clear how this information had been used to protect people better. We considered this further under the question whether the service was well-led.

We found that for the permanent staff whose recruitment records we sampled, the service had carried out appropriate employment checks. This helped to ensure that new staff were suitable to work with people who were vulnerable as a result of their circumstances. The service needed to ensure they also had this information available for all agency staff before they worked in the home. They had addressed this with a new agency they were using.

People living at the service we spoke with said they felt safe at Damfield Gardens. Relatives were happy that their family member was in a safe environment, but one relative said, "I feel my relative is safe, but I worry sometimes their buzzer is not next to them if they are sat in their chair." Another said, "My relative is prone to falls, but because they have the room sensor it makes me feel they are safer because staff react if they try and get up out the chair/bed."

Staff we spoke with understood their responsibilities to keep people safe. A staff member said, "My main concern is the resident, I make sure people are safe and happy." We also observed staff supporting people safely when they recognised the person was becoming distressed. The new manager and professionals agreed further training was needed to make staff more confident in supporting people through timely de-escalation and safe intervention. We discussed as part of this that some people's protocols for 'as required' medicines included good detail, while others needed clearer explanations for staff to use.

The service was generally clean and bright on the days of our visits. Regular health and safety checks took place to help maintain a safe building for people to live in. The provider was addressing some maintenance and environmental improvements. This included draughts in some people's bedrooms and corridors, which the provider was rectifying with their contractors. People and professionals also pointed out that there were some heavier ornaments loosely positioned on furniture in corridors. We considered these might pose a risk to people, if held by a person during times of distress.

Domestic staff we spoke with were knowledgeable about infection control. Hand sanitizing stations were available at regular points throughout the service. The provider's maintenance person showed us a selection of the service's health and safety checks. These had been carried out regularly and included fire

safety and water temperature checks. We mentioned to the provider that relatives had fed back call bells at times needed to be closer to people. At the time of our inspection, the maintenance person checked one call bell once a week. We discussed how this could be reviewed to ensure more people's call bells and availability thereof were checked more frequently.

Requires Improvement

# Is the service effective?

## Our findings

Communication within the service and with other professionals was not always effective. At times important information about people and their health and wellbeing had not been passed on or was not available.

For example, information about prescription changes had not been handed over between staff effectively. Staff at times did not have or find necessary information to help visiting nurses provide effective support to people with specific health needs, such as catheter care. Relatives felt that communication needed to improve within the service, as staff could not always tell them how their loved one was.

A person who lived at the service told us, "I am worried because I have asked about my flu jab several times but not had it yet."

Partnership working with a range of health professionals to support people's wellbeing was developing. Professionals commented that while it was good that the service was working closely with them, staff confidence in supporting people in certain situations needed to develop. We heard from managers and staff that they had initially found it difficult to build effective working relationships with other health professionals.

A weekly arrangement had been made to meet at the service and discuss at the people's health needs with specialist nurses. People had access to a range of health professionals, although GP referrals and access to out of hours services were noted by staff as difficult. The service was setting up a 'telemedical' service while we visited. These services offer assessment of people's health needs from a far and out of hours, to then make a recommendation for further treatment.

Damfield Gardens specialises in care and support to people living with dementia. Staff confidence and competence in specialist aspects of care needed to be developed to provide effective support. The service was working with external professionals to develop a more dementia specialist environment. This included improvement to the signage and orientation aids available to guide people. Good aspects of the environment we saw included level access to bedrooms for day areas, lounge furnishings that were well grouped and identifiable areas such as the hairdressing area and laid tables in the dining area.

People living at the service at times presented behaviours that challenge. All staff needed to be able to support people and those around them safely and effectively during times of distress, which was not always the case. This included the ability to deescalate situations before they led to incidents, or intervening safely and appropriately. Visiting professionals and managers within the service had identified that further training was needed to develop those more specialist, but necessary staff skills.

Before the service opened, staff had had a two-week induction that included a variety of classroom based learning. Staff who started more recently received a shorter induction, followed by electronic learning in a variety of subjects. There was no evidence of an induction for agency staff at the time of our visit. Managers put together a pack to ensure this following our inspection.

A person who lived at the service told us, "I have to be helped to my feet and some staff, especially agency staff do not seem to know how to turn me so I feel a little unsafe."

Staff we spoke with felt well supported by managers. A staff member told us, "I feel listened to and well supported. Support from [the registered manager] is above and beyond at times. Her feedback is always honest."

The service was aiming to complete 'one-to-one' supervision meetings with all staff at least every two months. The registered manager was aware that at times staff had not had such a meeting in four months. Supervision meetings are important as they help staff in their professional development and provide opportunity to voice any concerns.

The service needed to review aspects of working within the Mental Capacity Act to protect people's rights consistently.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Improvements were needed in the use of mental capacity assessments to check whether people could make specific decisions, such as around where to reside or the use of restrictive bedrails. The service had assessment tools in place, but they needed to use them more consistently.

We saw that the service had made appropriate applications to the local authority to deprive people of their liberty. The registered manager had rectified some previous delays in applications being made. We also saw good examples where staff had worked with other professionals in the best interest of the person. This included where the person needed to receive their medicines in a hidden, or 'covert' way, such as in foods or dissolved in drinks.

People we spoke with told us they had enough to drink and some also made their own drinks. When people needed support to drink enough to stay healthy, recording and actions were not always clear. We also found that health related care plans at times lacked detail to guide staff. When we spoke with staff, they were aware of what they needed to do, but this information needed to be clearer to all readers to be effective.

People living at the service had enough to eat and staff encouraged them to choose from a variety of meals. Alternatives were available if people changed their mind. A person living at the service told us, "Sometimes the food is not hot enough and the choices are just ok." Another person said, "It is usually very good, not much taste but its ok."

One relative said "The food is very good with plenty of choice, my relatives put on a stone in weight. They were not eating at home but enjoying the food here." Another relative also praised how the service catered for people who were diabetic. They told us, "The chef made a special cake for my [family member], who is

diabetic, using lots of fresh fruit."

Requires Improvement

# Is the service caring?

## Our findings

We observed staff treating people who lived at the service with kindness and respect. Interactions were warm and compassionate. However, our findings of significant risk to people and other improvement needs meant the service was not always caring.

People who lived at the service told us, "The atmosphere is great because the staff are always smiling." Another said, "It is great living here, it is like my home from home."

A senior staff member told us, "The staff here really go out of their way for our residents." Examples of this were staff volunteering to work Christmas Day, because they wanted to make it special for people, or staff bringing in something a person needed, on their day off.

We observed interactions between staff and people who lived at the service on both days of our visit. We did so throughout the day, when we walked around the home, in all of the lounges and dining areas. All of the staff we observed supported people in a friendly, caring way. We saw gentle, reassuring contact and staff greeted people by their preferred name.

Staff were patient and kind when responding to people's questions, including those that were asked repeatedly. Staff we observed were familiar with people's likes and dislikes. People we spoke with confirmed this, saying that they were always called by their preferred names and all felt that the staff knew them very well, apart from the agency staff.

We observed lunch being served and saw that tables were laid with table cloths, napkins and cutlery in an inviting way. Staff supported people to sit on chairs rather than in wheelchairs to eat their lunch. We found the food tasted good and was presented nicely. A couple of people mentioned it did go cold quickly, as it was served on cold plates.

Staff explained, "We go around and ask people what they would like to eat tomorrow, but it is just to give the kitchen a general idea. If people change their minds, it is no problem and something else is always available."

Lunch was very sociable and people were all chatting with each other or staff members. There was background music playing and we found this not to be intrusive. Staff did not remove plates unless they asked the permission of the person and asked if they had they finished.

Overall, relatives we spoke with were pleased with the care and said their family members were always treated with dignity and respect. Four relatives came to speak to us to let us know how highly they valued the service. A couple of other relatives mentioned that on occasion their family member had not appeared well presented and looked after, another mentioned clothes had gone missing. We discussed a couple of aspects for the service to improve on with the registered manager, to promote people's dignity and confidentiality.

Relatives gave us examples of how the service's care had made a difference to their loved ones and how staff made them feel welcome when they visited. A relative said, "[Family member] was very unsettled when [they] came in [to the service] but is now very settled and staff are good at getting her settled and more relaxed."

Relatives and professionals noted they had confidence the caring culture developing with consistent staff would help the service to improve.

The involvement of people in the planning of their care needed review. Relatives told us they had been involved in the writing of their family member's life history and had also been included in care plan reviews. However, there was no evidence of how people themselves had been included in the development of their care plans.

All of the people and relatives we asked felt confidentiality was maintained by staff at all times. A person told us, "I have never heard the staff discuss anyone else in front of me."

Requires Improvement

# Is the service responsive?

## Our findings

People had care plans and risk assessments in place to direct staff. These were not always detailed enough or up-to-date to be clear about the person's needs for all readers. People's individual needs were not always met.

A person using the service told us they enjoyed a bath, but because they did not have confidence in staff using the equipment, they had showers instead. Their relative told us, "My [relative] had two baths when they first came into the home but [they] felt the staff did not know how to use the bath equipment so [they] will now only have a shower even though [they] like a nice soak in the bath." We heard from another person that at night they did not always have a choice whether a female or male care staff member assisted them.

People who lived at the service, relatives and professionals told us they felt the doors in the building, including toilet doors, were at times too heavy for them to open. A person we spoke with told us, "I cannot open the bathroom door [on the corridor] by myself. I have to get a member of staff to do it for me and then wait for them to get me." The toilets had call bells installed, but this meant that people could not always use the bathroom independently. We discussed this with the registered manager and provider, who were addressing the issue. The service was installing foot releases to hold doors, that would automatically let go of doors in the event of a fire alarm. We considered however they may not solve the independency issues around the use of bathrooms.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had care plans around health needs or behaviours that challenge, these were not always detailed enough to guide staff. Staff had not always updated plans following incidents, to ensure risk and support approaches had been reviewed. We found for one person that had a catheter care plan, this was this was brief and lacked any detail. There were no charts recording fluid intake or output. These were needed because regular fluid intake helps to ensure the catheter keeps working and reduces the risk of infection. An initial assessment included a fluid monitoring chart over three days which showed the person was not getting enough fluid intake, then the fluid monitoring had not been continued. We considered the above as record keeping and governance issues further under the question whether the service was well-led.

Where a person had had two incidents involving other people living at the service on the same day, their care plan had not been updated with approaches for staff to follow. Staff completed 'ABC charts' to describe what had happened before, during and after an incident. This information had not always been used to then develop a more proactive plan, that would prevent incidents. It was also not clear if all staff were aware of the benefit of recording this information regarding personalising approaches.

When we spoke with some staff they were able to tell us about what they needed to do. However, as the service often relied on external staff covering shifts at short notice, clear information needed to be available to all readers of plans.

We note that we also found, observed and heard about good examples of the service's responsiveness. During our inspection, we observed staff supporting a person that was increasingly becoming distressed. We saw that staff engaged with this person in a calm, patient way, using personalised ways to distract them. A relative also told us, "Whenever anyone gets agitated on the dementia unit staff [support] them in a calm, caring way." As we considered under the question whether the service was effective, this needed to be supported further by robust training for all staff. Permanent and consistent staff also needed to share what they knew worked well for the person more effectively, to help other team members.

Good examples we saw in care plans were around preadmission assessments, people's life story and history, as well as personal and skin care needs.

The service had recently employed an activities coordinator and two activities apprentices. This was to develop the activities on offer within the home.

All of the people we spoke with told us they took part in any activities that were going on but they would like more, including community outings.

One person told us, ""There are some shops over there [looking out the window] but I cannot go out on my own." Their relative told us, "[Family member] needs to get out more. [they have] always been very active and independent. There was enough staff to support outings."

We spoke with the activities coordinator and they told us they had a good budget to work with, for example to hire entertainers.  There had been a singer for Halloween, which people and relatives told us they had enjoyed. The activities coordinator also spent time with people away from communal areas, to have a chat with and engage them.

The service had a hairdressing salon that was laid out just as one that may be found in the community. There was an area outside with magazines for people to read while they waited. People were smiling and looked like they were enjoying having their hair done when we visited.

We discussed with the registered manager how they were supporting people's diverse needs and communication.

We saw from activities plans that a holy communion was on offer for people to attend. The service's information pack for people using it made it clear however that the service welcomed and supported other faith needs. We considered that the service's information pack, or "welcome pack", was available in standard print only. We discussed this with the registered manager, who advised us of their plans to make information more accessible. This was important for example as the pack included information about how to make a complaint.

All the people we spoke with felt the staff listened to them and acted upon what they said. People and relatives we spoke with felt listened to. People for example told us they went to bed and got up at whatever time they chose to do so. Relatives either told us they had no reason to complain or that staff had dealt with their complaint.

We saw that the registered manager had recorded and acted upon complaints appropriately. They kept the complainant up to date until the point of resolution. Complaints were not high in number, but a common theme was the lack of communication.

We also saw compliments the service had received. A relative had written for example, ''You are doing a great job and making a massive difference. It is a wonderful place made so by the staff.''

The service cared for people at the end of their lives and relatives praised the staff for the support they gave at this time. A staff member told us, "I have not had specific training about this here, but I had it in my previous work." Professionals told us that at this point, staff were supportive, but the responsibility for their care was mainly taken over by external nurses. People had a plan of care in place to support them at the end of their life. We considered that these needed to include more clearly the person's own wishes.

Requires Improvement

# Is the service well-led?

## Our findings

Systems and records in place were not always operated effectively to promote the safety and quality of the care people received.

We found that the service had checks and audits in place to monitor the safety and quality of care. These included for example, care plan audits, accident audits, medication audits, kitchen audits, pressure sore and bed rail audits and monthly weight audits.

Audits were not always effective, as whilst they were completed and issues had been identified, often those issues had not led to an action plan to achieve improvement. Where they had led to an action plan, in the majority of cases there was no audit trail as to whether those actions had been carried out, who by and when. There was no clear oversight of audits by one central person to ensure the quality of the service, such as a manager, which meant there was not always consistency to the auditing in place. The registered manager was aware of these issues and explained previous management arrangements had led to significant improvement needs, such as a lack of consistent and robust auditing.

As a result, audits had been completed going back a few months and this impacted on their effectiveness. For example, an accident audit for the month of June was carried out in August 2018 and the information was not detailed enough to identify any trends or patterns to promote greater safety.

Accident and incident audits asked whether the person's care plan had been reviewed as a result. Where the audit stated this was the case, we found in fact the person's care plan had not always been updated. These audits also did not always pick up that incident and accident reports at times had not been fully completed or that information was incorrect. Care plan audits did not pick up on or improve the issues we found with regards to detail and record-keeping relating to people's personalised care.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we met with the new manager of the service, as well as the registered manager and provider. We found that all were honest and open throughout the inspection and responsive to our feedback. In conversation with the new manager, they had also picked up on improvement needs and told us about their plans, which was reassuring. The provider and registered manager were supportive of the new manager's fresh look at things, to help the service improve.

Throughout our inspection, we saw the managers, registered manager and provider walk around the building regularly. We saw they engaged with people who lived at the service, relatives and staff. We saw the provider led staff by example and engaging in a positive, calm way with a person who was becoming distressed.

People we spoke with told us the registered manager and provider were always approachable and felt that

they would act if they made a complaint. Relatives agreed and one said, "[Provider's name] is the Owner, he is always about and always asking if everything is ok. I feel that the service is improving all the time."

Staff told us, "[Registered manager] and [provider] are wonderful, we can always speak to them. It makes such a difference when they tell you have done a good job."

Staff had a large variety of policies in place to guide them in their role. Staff familiarised themselves with these policies as part of their induction. One of these policies described the service's approach to Equality and Diversity. This included a clear statement against discrimination of people using the service or staff, based on, "race, gender, nationality, religion, ethnic or national origin, disability, gender reassignment, sexual orientation, age, colour or social background."

Staff told us and we saw that team meetings took place regularly. Staff felt they were able to discuss any issues at these meetings. The provider and registered manager told us about things they had introduced to strengthen the culture of the service and make it more attractive as an employment of choice. This included a staff recognition scheme and other merits.

We considered that staff meetings could also provide a good opportunity to strengthen the developing culture of the service and responsiveness to people's needs. We discussed with the registered manager and provider how oversight processes and team meetings could ensure that night staff also felt included in the delivery of a quality service.

Residents' and relatives' meetings took place monthly. We saw that things discussed included for example activities on offer, such as the introduction of a minibus or a pet therapy dog attending.

The service was working with different stakeholders, such as families, the local authority and health professionals. Feedback examples were mixed, as described within the report. Those who had concerns agreed that they had confidence that, based on the open, honest and caring culture of the home, given time and support, the service would make the necessary improvements.

The registered manager had submitted certain notifications to CQC in line with legal requirements. We clarified with the registered manager the need to also send such notifications to CQC about any abuse or allegation thereof, whether the allegation had been found to be true or not.

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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The service did not always meet people's individual needs.<br>This included personal preferences, as well as enabling greater independence for people. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The management of people's medicines was not always effective.<br>People did not always receive the correct medicine and on time.<br><br>The assessment, monitoring and management of people's risk needed to be more robust.<br>Care plans and charts had not always been reviewed or completed effectively to mitigate assessed risk for people. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Audits and systems and processes to assess, monitor and improve the quality and safety of the service were not operated effectively.<br><br>Records to assess, monitor and mitigate the risk relating to the health and safety of people were not always completed or reviewed effectively. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not always enough staff to meet people's needs and keep them safe.<br>Not all staff were suitably competent and skilled to provide specialist care for people living at the service. |