Majorspan Limited

Tudor Court 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 2 and 7 November 2018 and the first day was unannounced. At the last inspection of the service in October 2016 the provider was rated as Good in all five key questions. At this inspection, we found that the key questions of Safe and Well Led were now rated as Requires Improvement.

Tudor Court 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. Tudor Court is registered to provide care, nursing and accommodation to a maximum of 29 older people, some of whom may be living with dementia or memory loss. At the time of the inspection, there were 21 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to the inspection we received a number of concerns about insufficient staffing levels, pressure area care and adequate welfare checks and supervision of people living in the home. As a result of these concerns we brought our comprehensive inspection forward to look into the care provided at Tudor Court.

Risks to people were assessed and risk assessments tools were used to identify common risks such as those relating to falls, skin integrity and medicines. However, daily monitoring records did not always show that care was being delivered as it should and checks on equipment used to reduce risk, were not always accurate. People were not always protected from risks associated with their environment. Some windows did not have window restrictors and one radiator did not have a cover fitted.

Improvements were required to ensure that medicines were managed safely. Whilst medicines were stored and administering safely, random sampling of five medicines found discrepancies with the stock levels of two medicines and staff were unable to tell us how much stock they should have of another medicine. During the inspection the registered manager amended their daily medicines audit to include stock checks of boxed medicines.

The provider had systems in place to monitor the quality and safety of the home, however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection.

People and relatives had differing opinions about the amount of staff available and if there was enough staff to meet people's needs. One person told us, "It seems to be fine. There are always some staff around. I have no concerns." However, another person told us, "They can be rushed off their feet." Staff also felt they were short staffed. One said, "It's terrible we are constantly short staffed. We are not spending enough time with

people. The only time you spend with residents is when you get them up in the morning." We made a recommendation to the provider to review their staffing levels to ensure people's needs were met.

We found that improvement was needed in relation to supporting people to maintain their social activities and interests to avoid the risk of social isolation. The provider arranged a programme of entertainers that came into the home to provide activity. There was no activity coordinator. The responsibility to generate activity fell to the staff team. However, staff told us, and we observed, that staff rarely had time to sit with people and engage them in an activity they enjoyed. One person told us, "There's nothing you can do here, only sit in the chair." People and staff told us that staff talked to them when providing care but did not have time to spend with them for one to one activities. We made a recommendation to the provider regarding the provision of one to one activities.

People told us that they felt safe and secure living at Tudor Court. Comments included, "Yes, I feel safe, there are always two staff" and "I feel safe and well cared for." People were protected from the risk of abuse because staff understood how to identify possible abuse and were clear in how they would report this. Staff told us they had received safeguarding training.

People were supported by staff that had been recruited safely and had sufficient knowledge and skills to enable them to care for people. There was a comprehensive staff training programme in place and staff told us they felt supported.

Staff respected people's privacy and dignity and interacted with people in a caring, compassionate and professional manner. People were encouraged to be as independent as possible but where additional support was needed this was provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way; the policies and systems at the home supported this practice. Where people lacked the capacity to make decisions about their care, the home had taken appropriate action in line with the Mental Capacity Act 2005.

People's care plans were comprehensive, person centred and detailed, providing staff with relevant and appropriate guidance in how to support each person. There was personal information in people's care plans describing how the person wanted to spend their time, their likes and dislikes and other preferences.

People's nutritional needs were being assessed and they were supported to eat and drink sufficiently. Where people required further input, referrals were made promptly to other agencies and people were encouraged to attend appointments with other health care professionals to maintain their health and well-being.

People living at the home, relatives and staff were happy with how the home was being managed. They found the registered manager and staff approachable. The registered manager regularly sought feedback from people living at the home and their relatives about the support provided. We saw evidence that the feedback received was used to develop and improve the service.

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

People could not be assured risks to their health, safety and well-being would be managed safely.

Systems and processes in place to ensure the safe handling of medicines had not always been properly followed.

We made a recommendation about ensuring there was enough staff available to meet people's needs.

Staff had been trained in safeguarding people and were knowledgeable about the potential signs of abuse.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to carry out their roles effectively.

People's capacity to make decisions about their care had been assessed in line with the Mental Capacity Act 2005.

People told us the food was good and choices were available to them.

People's health and nutritional needs were regularly assessed and referrals made to appropriate health professionals when necessary.

The premises were designed, adapted and decorated to meet people's needs and wishes.

Is the service caring?

Good

The service was caring.

People told us staff were always kind and caring.

People were treated with dignity and respect.

We observed good relationships between staff and people living in the home.

People were encouraged to retain an appropriate level of independence.

Staff supported people to maintain contact with their family.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider arranged a programme of entertainers to come into the home to provide activity for people. We made a recommendation about the provision of one to one activity.

People's care plans were comprehensive, person centred and detailed, providing staff with relevant and appropriate guidance in how to support each person.

There was a complaints system and people knew how to complain.

People were supported to have a dignified end to their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to monitor the quality and safety of the service had not been used effectively; this had led to the shortfalls identified during this inspection.

People, their relatives and staff were positive about the leadership at the service. Staff felt supported by the management.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

The registered manager understood their regulatory responsibility and had submitted statutory notifications as required.

Tudor Court 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 was planned to check whether the provider was 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 2 and 7 November 2018 and the first day was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. This included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority quality and improvement and safeguarding adults team to gather their feedback. We also looked at information in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took the information we had received into account when we inspected the service and made the judgements in this report.

We spoke with seven people who lived at the home and three relatives. As some people were unable to tell us their views of the service, we completed a 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. We spoke with four members of staff, a kitchen assistant and the registered manager. We also spoke with a visiting healthcare professional.

We looked at the care records for five people as well as records related to the management of medicines. We checked three records held in relation to staff recruitment and training. We looked at accidents, incidents, complaints and systems in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Risk assessments had been undertaken to enable people to retain independence and make their own choices, whilst minimising risk. Risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medication.

People who were at risk of developing pressure ulcers had pressure relieving equipment in place such as pressure relieving mattresses and cushions. However, when we checked mattress settings we found one person's pressure mattress was not set correctly for the person's weight. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage. The mattress was set for a person of 110kgs. The persons last recorded weight on 1 November 2018 was 73.7kg. There was no mattress check form available in the person's room. Previous mattress checking forms available to us demonstrated that the mattress was set correctly from 13 August to 7 September 2018 but incorrectly set at 110kg between 23 and 31 October 2018. The correct setting for this person's mattress was not written in their care records. This put the person at risk of pressure damage.

Despite the pressure mattress being incorrectly set, there was no evidence the person had been adversely affected by the incorrect setting or had developed pressure ulcers due to lack of care.

The registered manager could not be assured that care was being delivered as it should, to mitigate risks. For example, one person had a significant risk of developing pressure ulcers. Risk assessments had identified the need for regular repositioning. However, their daily repositioning and skin inspection chart did not demonstrate this had taken place consistently. For instance, their repositioning chart for 1 November 2018 showed they were repositioned during the night every three hours until 9.30am. From 9.30am their repositioning chart showed their position was then not changed until 16.30pm. This meant the person was put at increased risk of pressure damage to their skin because they had not had their position changed regularly.

Some people were at risk from dehydration and were having their fluid intake monitored. However, staff could not be assured that people were having enough to drink to mitigate the risk. Fluid intake charts did not inform staff how much fluid the person should be drinking a day to avoid dehydration. Fluid intake charts were not totalled up at the end of they day to see how much a person was drinking. This meant staff could not be assured that people had enough to drink and therefore take action if they fell short of their target amount. The registered manager told us these charts were not formally audited or reviewed.

Following the inspection, the registered manager implemented new fluid balance charts that documented people's fluid intake for each day. These charts were submitted to the management team daily for review.

People were not always protected from risks associated with their environment. Windows in the conservatory and one window in a bedroom did not have window restrictors which complied with Health and Safety Executive guidance. We saw one radiator at the bottom of a staircase did not have a radiator cover. Staff told us the staircase was in use by some people living in the home. The staircase was accessed

by a door and was not visible from the communal areas of the home. This put people at risk of burns if they were to fall against the uncovered radiator. We brought this to the attention of the registered manager who said they would take action to address this immediately.

Following the inspection and prior to the report being published the registered manager sent us photographs of the completed radiator cover and window restrictors.

Improvements were required to ensure that medicines were managed safely. We looked at people's medicines administration records (MAR) and saw that these had been completed with no missing signatures. However, random sampling of five medications found discrepancies with the stock levels of two medicines. One person's epilepsy medicine showed an overstock of four tablets. This could indicate that medicines had been signed for but not given, as they remained in the blister packs. Another person's warfarin medicine record had not been carried over on their MAR chart from the previous months MAR charts and staff were unable to tell how much of this medicine they should have in stock. We also saw two tablets had been popped out of the blister packaging in the box, not used and placed back into the tablet cavity.

We discussed the stock discrepancies with the registered manager. They told us they would ensure staff checked boxed medicines as part of their daily medicines audit to reduce the risk of this happening again.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicine management were managed safely. We observed staff administering medicines in a safe, calm and unrushed manner ensuring people received the support they required. For people that were prescribed 'as required' medicine, such as pain relief there were guidelines in place which told staff when and how to administer the pain relief in a safe way. Where people had allergies, this was recorded on their MAR, and staff who gave medicines knew about them. Staff who administered medicines received appropriate training, which was regularly updated, including having their competency checked.

People and relatives had differing opinions about the amount of staff available and if there was enough staff to meet people's needs. One person told us, "It seems to be fine. There are always some staff around. Even the staff in the kitchen chat to everybody. I have no concerns." However, another person told us, "They can be rushed off their feet. It's affecting the care they give. You might have to wait a bit longer for things." A relative told us, "There's times when they could do with more staff. If they are short staffed it makes a difference to the number of people on the floor to watch over the residents, and there are not enough staff to look after residents in the sitting room. My relative has help to wash and dress and cut up his food." Another relative told us, "I would like my husband to sit at the dining table for meals but he currently sits in armchair in the sitting room. I think it may be because of a lack of staff. He needs to be taken in a wheelchair which takes time."

One staff member told us, "The staffing's not good. We are always short staffed. We do need to have more staff on the floor." Another said, "It's terrible we are constantly short staffed. New staff are not staying and they leave. We are not spending enough time with people. The only time you spend with residents is when you get them up in the morning. It's difficult to go in and spend time with them. The television is used to entertain. They are just sitting there." A visiting health professional told us, "There is not always staff around in the lounge and sometimes I've had to go looking for them."

Staff told us staffing levels used to be four care staff on duty in the morning and afternoons plus a senior

carer. One said, "Agency staff are not used and problems mainly occur when staff call in sick and their shifts are not covered." The registered manager told us core staffing levels for Tudor Court were three carers and one senior carer throughout the day with two waking carers at night. During the day staff were supported by the registered manager, deputy manager, cook, kitchen assistant and two cleaners. The registered manager told us that they did not use a dependency tool but regularly assessed people's needs and increased staffing levels when needed.

We recommend the home reviews its staffing arrangements and how staff are deployed to ensure people receive the care, support and supervision they require to meet their needs and protect their safety.

People told us that they felt safe and secure living at Tudor Court. Comments included, "Yes, I feel safe, there are always two staff", "I feel safe and well cared for" and "I am fine, they [staff] are very good, they look after me very well." People told us they could talk with staff if they had any concerns or worries. One person said, "I would speak to a senior, or manager. I am very confident that it would be dealt with appropriately."

People were protected from the risk of abuse because staff understood how to identify possible abuse and were clear in how they would report this. Staff told us they had received safeguarding training. Staff told us they would raise concerns outside of the organisation if they thought that the matter was not being addressed effectively.

People were protected from being cared for by unsuitable staff. We looked at three staff files and found they contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (police checks).

Records showed accidents and incidents were recorded and reported. Appropriate actions were taken such as first aid being applied and referrals being made to other health care professionals. Accidents and incidents were analysed in a way which enabled trends to be identified and action taken to reduce risks.

The environment was clean and well maintained. One relative commented, "My relative's room is always immaculately clean. There's no smell, it's not depressing and it's light and bright." There was an on-going programme to re-decorate and make other upgrades to the premises when needed. Staff had access to personal protective equipment such as disposable gloves and aprons. We observed staff wearing these when providing personal care to people.

We saw records and certificates that showed appropriate audits and safety checks had taken place. Each person had a personal emergency evacuation plan (PEEP), which contained details that may be needed to keep a person safe in the event of an emergency.

Good

Is the service effective?

Our findings

People were supported by staff who had sufficient knowledge and skills to enable them to care for people. There was a comprehensive staff training programme in place and staff received updates were needed. Where people had specific healthcare needs specialist training was arranged such as pressure area care, death and dying and caring for people living with dementia. Other training included safeguarding adults, food safety, health and safety, moving and transferring and first aid.

Staff were effectively supported. Staff told us they felt supported in their work. Staff had regular one to one meetings which took place with their manager. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. Staff told us they could approach management anytime with concerns, and that they would be listened to and the management would act.

People had received pre-assessments of their needs before moving to the home. On-going assessments and reviews of people's needs were carried out as required. Staff had a good understanding of each person's specific needs, wishes and lifestyle choices, and people were not discriminated against.

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 people 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 and found that people's rights were being protected. Mental capacity assessments had been undertaken when it appeared likely that a person lacked the necessary mental capacity to make decisions about important things that affected them. The registered manager had involved key people in a person's life to ensure that decisions made on their behalf were in their best interests. Staff attended training on the principles of MCA. Staff were aware of when people, who lacked capacity, could be supported to make everyday decisions and when people's capacity fluctuated due to living with dementia. Staff gained people's consent and explained how they were going to support people before giving them their medicines, supporting them to eat or providing personal care.

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). Applications had been made for those people whose freedom was restricted to keep them safe and these were renewed within set timescales to ensure the service was acting lawfully.

People told us they enjoyed the food at Tudor Court. One person said, "The food is fantastic. It's cooked good. You always get a choice. You can choose something else if you don't like it." A relative commented, "The food seems to be good. Freshly cooked and you get a choice. He's eating everything."

Food was homemade and freshly prepared and looked appetising. People were offered snacks throughout

the day including homemade cake and fruit which meant there was not long periods between meals. Staff regularly offered people hot and cold drinks throughout the day to ensure they were adequately hydrated. Information about each person's dietary requirements such as if they required a soft diet, diabetic diet or thickened fluids was available for staff. We saw people who had been assessed as requiring a soft diet, were provided with this for lunch. People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. People's weights were monitored and referrals made to the dietician when people had gained or lost significant weight.

People told us that if they needed to they could see a health professional. One person told us, "They[staff] contact the GP. Some time ago I had a chest infection and they gave me antibiotics." Another person told us, "I go to the doctors. One of the staff take me." Records demonstrated that people were supported to attend hospital appointments and information from those visits was shared with relevant staff to ensure changes to treatment were actioned. People were referred to professionals such as their GP, community nurses, the chiropodist and dentist as required.

The premises and equipment within the home met people's needs. Communal spaces were spacious and uncluttered which gave an air of calm and comfort. The provider had redecorated the home and best practice design for people living with dementia was being followed. Examples of these included clearer signage with pictures to help people navigate around the building. Bedroom doors were personalised with a number and the name of the person. There was a noticeboard in the lounge which showed the date and time and pictures of what foods were available for lunch.

Good

Is the service caring?

Our findings

People told us they felt well cared for. Comments included, "I like it here", "This is my home" and "It's very nice, everybody is nice." A relative told us the home had been suggested to them, "He liked it from the first visit and he's happy here." Another relative told us they thought their relative felt safe in the home, "He says he likes it here, the food is good and he is looked after very well." A health professional told us, "The staff are all very kind and caring and they speak nicely to the residents."

Staff used a calm manner and were polite, friendly and attentive to people. Staff used people's preferred names when they engaged in conversation. One person told us, "They call me [first name]. I'm happy with that." We saw that staff often touched people when speaking with them, for example, staff at times placed their hand on the person's arm or shoulder to offer comfort. We saw staff crouch down to speak to people at eye level. When people became confused with their surroundings and were not sure where they were, staff checked with them where they wanted to go and supported them to go to the room of their choice.

Staff spoke warmly about the people they supported and provided care for and said they enjoyed working at the home. One member of staff said, "I enjoy it, I love care, just looking after someone. It's all about making sure they have a good day." Throughout the inspection it was evident staff knew the people they supported. They could tell us about people including their interests, as well as medical support needs. Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

People confirmed the staff respected their privacy when providing care. One person said, "They are always knocking on the door. They pull the curtains when I wash." One staff member said, "I always speak to them with respect and make sure I use the correct language. I make sure they are covered during personal care and always give them the choice of what they want to do." We saw staff were considerate of people's privacy, they knocked on people's doors before entering, and only discussed private matters with people in privacy. Suitable arrangements had been made to ensure that private information was kept confidential. This included written records that contained private information being stored securely when not in use.

People were actively involved in making decisions about their care and treatment and to maintain their independence as far as possible. People were asked what they wanted to eat and drink and how they wanted to spend their time. People told us how staff encouraged them to be independent, with one saying, "They help me a lot in some ways. I try and do things myself. They encourage you to wash, and stuff." One staff member told us, "We always ask people and try to encourage them to be as independent as possible like passing them the flannel rather than doing it for them.

Relatives told us they were made welcome when they visited and that they had good positive relationships with staff. One relative told us, "We are welcomed as visitors. Offered tea and coffee." Another said, "The staff always ring me about any concerns, they are really good."

Requires Improvement

Is the service responsive?

Our findings

People told us staff understood their healthcare needs and respected their choices and the decisions they made. However, we found that improvement was needed in relation to supporting people to maintain their social activities and interests to avoid the risk of social isolation.

We looked to see how people spent their day and what activities were carried out at the home. We were told the home used to have an activities coordinator, however this person left a while ago and the registered manager told us there were no plans to recruit a replacement. This meant the responsibility fell to staff to generate and carry out activities as well as attend to peoples physical care needs.

During the inspection we looked at the homes activity book which was used to demonstrate what activities had taken place, who had attended and if people had enjoyed the experience. This included organised activity and when staff had provided one to one activity. However, staff told us and we observed, that staff rarely had time to sit with people and engage them in an activity they enjoyed. Other than when people were entertained by organised entertainers brought into the home to provide activity, people were seen to be sitting in the main lounge with little to entertain or occupy them other than the television playing in the background. One person told us, "There's nothing you can do here, only sit in the chair. Just sit here and talk to one another. I chat in the evening until bedtime or watch TV. Whatever comes on."

Some people chose not to take part in organised activities or stayed in their rooms because of their health needs and therefore could be at risk of becoming isolated. We saw staff checked on people and responded promptly to any call bells. However, people and staff told us that staff talked to them during providing care but did not have time to spend with them for one to one activities. One person told us, "They [staff] don't stay and chat, but they do pop in to see I'm okay. Not very often, but they do come in."

We spoke with people about activities and people expressed that they would like to see more but that they enjoyed the things that were offered. One person told us, "I have a regular place to sit where it's quieter. I like the music and the animals when they visit. I usually just read a newspaper or magazine." A relative told us, "They have music afternoons. Last Friday we had all the animals in, rabbits, guinea pigs, snakes and he brings enough for everybody to hold. A donkey came earlier this year. They also have a craft morning on a Monday."

We recommend the home take advice and guidance from a reputable source regarding the provision of meaningful one to one activities for people including people who are being cared for in bed, or who choose to remain in their rooms.

An assessment of people's individual needs had been completed prior to admission to the home to determine if they could provide people with the right level of support they required. A relative told us, "The planning process was very impressive. We went through everything and [relative's name] needs. She [registered manager] also gave me some things to do at home – his life, where he was born. She told me 'we go through that with all the staff so they know all about him'. They have kept the book here."

People's care plans were based on their initial assessment, and were person centred and detailed, providing staff with relevant and appropriate guidance in how to support each person. There was personal information in people's care plans describing how the person wanted to spend their time, their likes and dislikes and other preferences. For example, what clothes people prefer to wear or how they took their tea or coffee. This meant that people received care that was totally individualised, person centred and based on how they wanted to be treated and looked after.

Care plans were updated when people's needs changed and we noted that plans included guidance for staff on the level of support each person required. Daily records were maintained to demonstrate the care provided to people. Staff knew people well, who they were and how they liked to be cared for. For example, staff were able to tell us what time each person preferred to get up in the morning and what time they went to bed. They could tell us about people's dietary preferences and what they liked to drink. Staff told us they knew how to look after people because they had consulted their care plans.

Since August 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. Care plans documented the communication needs of people in a way that met the criteria of the standard. There was information on whether people required reading glasses or hearing aids and any support they might need to understand information.

People living at the home at the time of our inspection, had similar ethnic backgrounds and religious beliefs and there was nobody with an obviously diverse need. People were asked about their cultural and spiritual needs during the care planning process and staff supported people when it was needed.

People said they felt confident to approach a member of staff or the registered manager if they had a worry or concern. One person told us, "I know who the manager is. I would go straight to her." Arrangements had been made to support people if they wanted to make a complaint about the home. The complaints procedure was displayed on the notice board at the entrance and given to people and their relatives when they first came to live in the home. The registered manager followed the provider's complaints procedure and we saw that complaints had been fully investigated and responded to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. People had been consulted about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. They had been with the home since September 2017 and registered with the Care Quality Commission in August 2018. 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.

The provider had systems in place to monitor the quality and safety of the home; however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection. For example, the weekly maintenance audit we looked at during the inspection had not identified that some windows did not have window restrictors in place and one radiator was not covered. Medicine audits in place had failed to identify the issues we had identified with medicines stock.

Although the registered manager was working towards improving the home and the quality assurances processes, the day-to-day monitoring and observations of care and support within the home was not always effective. Daily monitoring records did not always show that care was being delivered as it should and checks on equipment used to reduce risk were not always accurate. For example, daily management spot checks had failed to identify that people were not being turned frequently during the day to reduce the risk of skin damage, and incorrectly set equipment was not identified.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were complimentary about how the new registered manager was running the home. They said there had been a lot of positive changes over the past 12 months and that they felt things were now 'settling down'. One person said, "She's lovely [registered manager]." We asked people if they thought the home was well led, one person replied, "I would say so. I think she [registered manager] is quite progressive in her thoughts. She's all about the welfare of the residents. She was painting the nails of the ladies one Saturday. It's the extra little touches that make the difference."

Staff told us they were happy working at the home and felt supported by the registered manager. Comments included, "[Registered manager's name has made a lot of improvements. I feel able to approach her" and "She's very, very good and brought some brilliant ideas into the home. Any problems she deals with them. She pops in and out constantly asking if there is anything she can do and interacts with the residents." Systems were in place to ensure staff were trained for their role. Staff meetings were held to share information and provided staff with an opportunity to raise concerns, share ideas around good practice and learn together from incidents and outcomes to complaints.

The provider sought feedback from people living at the home about the support they received. The registered manager told us that satisfaction surveys were given to people and their families yearly to gain their feedback about the home. We reviewed the results of the latest questionnaire and saw that people had

expressed a high level of satisfaction with most areas of the home, including how they were treated by staff, activities, food choices, home decoration, cleanliness and if they were happy at the home. Comments included, "They are very well treated and cared for", "We are pleased with the care and attention you give [name]", "The home is spotless. I have even seen the wheels on the tables being cleaned" and "Excellent staff and the manager is superb."

We saw action had been taken where areas for improvement had been identified. For example, one person commented about the frequency of chicken on the menu. As a result, the registered manager responded by speaking to people about menu choices and reviewed the menus.

During the inspection we saw improvements had been made to the home environment since our last inspection. Work had been completed to improve access for wheelchairs and hoists, to a toilet near to the main lounge. Extensive re-decoration and new carpets and been completed throughout the home and the provider had secured a community grant to make the garden dementia friendly and more accessible to people. The registered manager told us that further improvements to the home environment were planned.

The registered manager told us they worked in partnership with other agencies, including local authority commissioners and healthcare professionals who were involved in supporting people. We received positive feedback from a social care professional. They told us they found the registered manager was professional, approachable and communicated and acted promptly.

The registered manager was aware of the legal responsibilities in notifying the CQC of significant events and incidents within the home. Notifications received were detailed and showed that action was taken to meet people's needs and risks were managed. The provider was aware of the legal requirement to display the registration certificate and rating from this inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with their care or the environment they lived in. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service had not been used effectively; this had led to the shortfalls identified during this inspection.