The Orders Of St. John Care Trust

OSJCT Hungerford House

Inspection report

Beechfield Road
Corsham
Wiltshire
SN13 9DR

Tel: 01249712107
Website: www.osjct.co.uk

Date of inspection visit:
01 October 2018
02 October 2018

Date of publication:
06 November 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place 1 and 2 October 2018 and was unannounced.

Hungerford House 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.

Hungerford House provides accommodation and personal care for up to 49 people. At the time of our visit, 47 people were using the service.

The home was last inspected in September 2017 and was rated as Requires Improvement, with a warning notice for medicines management. At this inspection we found that action had been taken to address the breaches in regulation and the medicines warning notice. We found the service to be rated as Good overall, with the domain of safe rated as Requires Improvement.

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.

We saw that there had been improvements in the way that medicines were managed. There was a reduction in the number of medicine errors and we saw medicines being administered safely.

We received mixed feedback about whether there were enough staff. There was a dependency calculation tool in place showing a minimum and maximum number of staff required. Rotas showed that the staffing levels were regularly at the lower end of the dependency calculation.

Although there were safe recruitment processes taking place, there was not always a managerial overview of this. A matrix was in the process of being created, documenting the information that had been seen and was held on file for each staff member.

Staff received training suitable to their role. However, there was no up to date overview of any gaps in training needs. We saw that this was a work in progress and time had been allocated to the administrator to complete this.

Staff understood their responsibility to identify and report any concerns relating to safeguarding. They knew who they could contact within the organisation and who they could whistleblow or raise concerns with externally.

Accidents and incidents were reported and analysed. We saw records showing that trends were identified

and actions were taken where possible to reduce the likelihood of recurrence.

People told us they felt safe living at the service. They told us staff were kind and caring.

There was pressure relieving equipment in place to support people's skin integrity. Records were maintained to show that people had been repositioned. We saw some gaps in recording and recommend that the records are monitored to improve consistency.

Where people lacked the mental capacity to make certain decisions, appropriate assessments and documentation was in place. Deprivation of Liberty Safeguard authorisations had been requested from the local authority.

If people were at risk of malnutrition and dehydration, their nutritional intake was monitored. We saw that records were maintained and people's weights were monitored.

There was an open culture of wanting to receive and using feedback to improve the service. An annual survey was circulated and regular meetings took place to obtain people's views.

People were mostly positive about the food options. We saw that catering audits took place and the kitchen staff engaged with people to seek their feedback.

Staff from all departments interacted with people, we saw housekeepers and kitchen staff taking time to stop and chat with people. The staff team worked well together to meet people's needs in a timely manner.

Staff were respectful of people's dignity. We saw staff discretely supporting people to use the bathroom and change their clothing had food spillages.

Complaints were investigated and responded to. We saw records showing that accountability had been taken where the service was found to be at fault.

Staff spoke positively about the support they received from the registered manager. The registered manager supported staff to take accountability for different aspects of the service and to develop in their roles.

The registered manager had a clear vision for the service. Where actions had been identified following audits, there were realistic timescales in place. Where there had been areas for improvement, changes were made and quality monitoring processes were put in place.

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.

Improvements had been made in the management and administration of medicines.

Recruitment records were not readily available or accessible to the registered manager.

People did not always feel there was enough staff.

Risk assessments were in place.

Staff understood their responsibilities to identify and report abuse.

Is the service effective?

Good

The service was effective.

Some records to document people's repositioning, were not up to date.

Where people lacked mental capacity, assessments, best interest decisions and DoLS applications were in place.

Where health or social care referrals were required, these were made in a timely manner.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and friendly.

The service received compliments from people and their relatives.

Staff stopped to speak with people. They supported people to maintain a well-kempt appearance.

People's dignity and privacy were respected and promoted.

Is the service responsive?

Good

The service was responsive.

Care plans were in place, which included assessments of people's needs, as well as their preferences.

There was an activities programme. We received mostly positive feedback about this provision.

Complaints were investigated and responded to.

Signs of deterioration in people's condition were recognised, their needs were then reviewed accordingly.

Is the service well-led?

Good

The service was well-led.

The registered manager had driven improvements with regards to medicines management and care planning.

Staff told us they felt supported by the registered manager.

The registered manager had a clear vision for the continuous development of the service.

OSJCT Hungerford House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 1 October 2018 and was unannounced. We returned on 2 October 2018 to complete the inspection. The inspection was conducted by two inspectors, a medicines inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection took place, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager 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.

During our inspection we spoke with 17 people living at the home and five relatives. We also spoke with 11 members of staff, including care staff, administration, housekeeping, activities, and kitchen staff. We spoke with the registered manager and area operations manager. In addition, we met and spoke with three visiting health and social care professionals. Feedback was gained either through informal conversation, or more formal interview.

We observed care practice and interactions. In addition, we reviewed documentation and records relating to people's care. This included care plans and records for 12 people. The medicines inspector observed the medicines rounds and inspected all aspects of medicines management. We also viewed information relating to the management of the service. This included audits, rotas, the training matrix, and staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

At the previous inspections in 2016 and 2017, we found that medicines were not being managed safely. In September 2017 we issued a warning notice for the repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safe management of medicines. In May 2018 we visited the service unannounced to monitor the medicines management systems. We found that improvements were still required and medicines were not being managed safely. At this inspection we found that improvements had been made. There were safe and effective processes in place and medicines were being managed safely. We found that the requirements of the warning notice had been met and the service was no longer in breach of Regulation 12. We have made a recommendation regarding the ongoing management of medicines.

Medicines were stored safely and checked thoroughly. The registered manager had introduced daily checks of medicines requiring additional secure storage. We observed these being counted and checked by two members of staff. We completed medicine stock checks and found these to be correct.

Staff competencies were checked and additional training was provided if required. After each medicines administration round, the records were checked by a different staff member. This reduced the likelihood of gaps in signatures, or medicines being missed. We checked the administration records and found them to be up to date.

People's topical prescriptions, such as creams and lotions, were administered safely. We saw body maps showing where the prescription should be applied, and clear directions for application. The records were up to date and showed that people received their prescription in accordance with the prescribers' directions.

There were some aspects of medicines management where improvements were required. We saw one staff member sign to say they had administered nutritional supplements to a person, however, they did not observe this. The written administration record details for one person stated that their medicine should be administered once a day. We saw that this was being administered twice a day. The medicine box from the pharmacy stated twice a day, so incorrect directions had been recorded in the hand-written instructions for one person. However, the person was receiving their medicines in accordance with the correct instructions provided by the pharmacy. There were also missing protocols for the administration of digestion supplements for three people.

We recommend that the service monitors the medicines management systems thoroughly, to ensure that improvements are sustained.

While there were recruitment processes being followed, the evidence for the registered manager to assure themselves of the safety of these checks was not always available. We were told that three recruitment files were yet to be fully made, including staff who had been working at the service for two months. One staff member had a recruitment file containing their application, interview and Disclosure and Barring Service (DBS) check; but there were no employment or character references. Records of these were obtained during

the inspection. A DBS check allows employers to check whether the applicant has any convictions, or whether they have been barred from working with vulnerable people.

The area operations manager assured us that the organisation's electronic systems would not permit them to progress with an application without sufficient supporting documentation, such as reference checks in place. However, this was handled by the head office, rather than the registered manager. The registered manager confirmed that work was underway, to ensure that recruitment documents were more accessible to them.

We recommend that the service implements a system that ensures the registered manager has access to an overview of each staff member's recruitment file.

We received mixed feedback from people, relatives and staff about whether there were enough staff to meet people's needs. Staff told us that when there were periods of sickness or absence, this impacted upon the time they had to spend with people. One person told us, "We have call pull bells and they come as quickly as they can, but they are sometimes short staffed so aren't so quick responding." One staff member said, "We are spread a bit thinly, but they do try and get more in if we are short. We have enough to do the basics." Another staff member explained, "It seems okay, we can help on other units if they need it. We are sometimes short staffed, so we can't always spend enough time with people."

Staffing rotas showed that staffing levels were not consistent each day. The staffing levels were decided using dependency calculations, with a minimum of six staff required, but a target of eight staff per daytime shift. On some days there were six or seven members of care staff. Care staff told us that the registered manager helped the team when there was a shift that could not be covered. One staff member said, "[The registered manager] will roll their sleeves up and get involved with what we need to do if we are short staffed." The registered manager explained that they will schedule agency staff to cover shifts where they know in advance that alternative cover cannot be arranged. This meant that some days staff would be able to spend more time with people. During the inspection there were eight members of care staff during the day and this meant that staff had time to engage and interact with people.

People told us they felt safe. Their feedback included, "I always have felt safe, I don't feel any danger here." Also, "We feel safe here, there's no rushing about, the people are nice and the staff are very helpful."

Staff understood the different types of abuse and their responsibility to report any safeguarding concerns. They explained they received safeguarding training and knew they could raise concerns with a senior member of staff and the registered manager. Staff also knew which agencies they could contact external to the organisation to raise concerns or whistle-blow.

Risk assessments and care plans relating to people's safety were in place. We saw risk assessments and care plans relating to falls, moving and handling, tissue viability and malnutrition. These were fully completed and reviewed monthly.

Accidents and incidents were reported and reviewed by the registered manager. We saw records evidencing that falls were analysed. This included looking at the frequency of falls each month, where they occurred, the time of day, and whether an injury was sustained. Support systems were then reviewed for people who had fallen, to see if there were any preventative measures or changes to their care required.

The home was clean throughout and free from odours in most places. We discussed with the registered manager that there were some corridors where odours were present. They explained that the provider was

planning to make changes to the carpets. They told us that some had already been replaced because of odours. Housekeeping staff explained their daily checks and that there was always a member of the team present each day of the week.

Maintenance issues were logged in a request book. The maintenance operative then prioritised the requests and we saw that these were actioned promptly. There was a record of water and fire checks, ensuring safe systems were in place.

Good

Is the service effective?

Our findings

People's skin integrity was supported through repositioning and the use of pressure relieving equipment. We saw that air cushions and mattresses were in use and positional changes were recorded. However, we saw that three records had not been completed for the night of 1 October 2018.

We recommend quality checks for repositioning charts take place to improve record keeping practice.

People's health needs were recorded in their care plans. For example, people had oral health assessments in place, with directions for supporting their mouth care needs. We saw that people's routines with regards to appointments were recorded, such as, "is seen by the chiropodist every six weeks." There were records relating to opticians and hearing appointments. Care plans also indicated how staff could identify if the person was in pain. For example, in one person's care plan it was recorded, "When I am in pain, I verbalise by saying 'it's smarting'."

Where people's condition, needs, or behaviours changed, there was prompt consultation with health and social care professionals. We saw recorded in one person's records that trends in the number of falls they had experienced were analysed. Relevant professionals were then contacted in response. The record stated, "25 September, [Person] has had three falls. These falls have been known to happen late afternoon/evening. The GP has been consulted. GP will review on 26 September."

Where people had been assessed as being at risk of malnutrition or dehydration, their food and drink intake was recorded and monitored. We found these records were appropriately maintained and up to date. Fluid intake targets were stated and totals were recorded. Food intake records seen indicated that people received or were offered regular meals.

The kitchenettes in the dining rooms of each unit had 'hydration stations'. These were blackcurrant drinks that people could help themselves to. The drink was sugar free and noted as being diabetic friendly. There were water dispensers and disposable cups for people to help themselves. Snacks of crisps, chocolates, and fruit were also available in each unit.

People were supported by staff who worked well together to promote nutritional intake. We saw people being offered second helpings at each meal. Staff knew who had eaten a little amount of their main meal, but had enjoyed the pudding, so they were offered additional portions of what they had enjoyed. We saw people being provided with a choice of drinks throughout the day and these were topped up at regular intervals. Staff spoke about encouraging certain people with their fluid intake, particularly where the person had been reluctant to engage in eating their lunch. Some people preferred to eat 'on the go' and staff were aware of who needed fingers foods that they could eat while they were moving.

Most people were complimentary about the meal options. The positive feedback included, "It's very good, we get a reasonable choice of menu." Also, "The food is great, I eat everything." The less positive comments included, "It's alright, not a great choice though."

Staff were supported by staff who were well-trained and equipped with the skills to meet their needs. We saw records confirming that staff had received mandatory training in areas such as dementia awareness, safeguarding, health and safety, and manual handling. New staff completed the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

The training records were not accurately reflected on the training matrix. An up to date matrix provides an overview staff training and can reduce the likelihood of training becoming out of date. The registered manager explained that they had records to show who had attended which training sessions, but they were working on developing an up to date matrix.

Staff received one to one supervision meetings with their senior, but these were not on a regular basis. Staff told us they felt this was an area that was improving. One staff member said, "I've not had one for a while, but I think it is being sorted." Staff explained that they felt they could raise any issues or concerns during the supervision and staff meetings. Records showed that new staff had personal development reviews with their mentor during their probationary period.

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.

Where people lacked mental capacity, records showed that relatives and professionals were consulted with as part of the decision-making process. This ensured that people's previous wishes and care needs were taken into account when making decisions in the person's best interests. Some people had appointed family members as their Legal Power of Attorney (LPoA), which empowered them to act on their behalf. Care plans documented whether the person had an appointed LPoA and whether this was for health and welfare, or for property and finances. Where one person's LPoA had passed away, we saw records showing that the registered manager had consulted with the Court of Protection to identify if there were any other LPoA's in place for the person. Staff understood who should be consulted in relation to specific decisions. This ensured that people's legal and human rights were upheld when best interest decisions were made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS authorisations as required and the service was compliant with the conditions of the DoLS for each application.

There were plans to introduce a greater use of care technology. The registered manager explained that trials and consultations were taking place within the organisation regarding these updates. This included the plans for introducing electronic care planning and record keeping, also voice activated media control systems. For example, systems allowing voice controlled access to music and the news.

Good

Is the service caring?

Our findings

The service was caring. People and their relatives told us they felt they were supported by a caring staff team. Their comments included, "The staff are wonderful here" and, "I can't fault the care." Also, "The staff are very kind, very friendly too."

Compliment cards were received, from people and relatives thanking the caring staff team. One compliment card read, "We wanted to thank you for the professionalism and care you showed [relative] during their brief stay and in particular the last few days. [Relative] always told us how well they were looked after and we are very grateful they were in such good hands. Thank you." Another compliment card thanked the staff team for the support provided to a person during their short-term stay at the home. The card read, "To all the staff at Hungerford House. Many, many thanks for all your kindness whilst I have been here, it has made my stay more enjoyable."

We saw kind and thoughtful interactions between staff and people. One member of staff supported a person to walk to the dining table and asked, "Do you know everyone at the table?" They were ready to introduce people to help the person feel more comfortable. This considerate approach contributed to a positive dining experience during lunch.

Staff engaged in conversations with people while they worked. We saw staff completing records in the dining room and sitting with people while doing so. They chatted with people, asking how they were and about their day. Staff also joined people for lunch and encouraged conversation while dining.

Staff supported people to maintain a well-kempt appearance. We saw one person walking arm in arm with a member of staff. They went to the hairdressing salon and the person had their hair curled to start the day. The person received compliments on their hair from staff throughout the day. We observed that if people had dropped food on their clothes, they were supported by staff who discretely offered to help change the item of clothing for clean ones. For example, we saw one person was supported to change their outfit three times during the day. Staff were patient and pro-active in offering this. The person received compliments from staff throughout the day about how smart they looked.

People's dignity was promoted. We saw one person had a loose-fitting pair of shorts on. One member of care staff offered them a belt and quickly went to get this for them. Another person was respectfully and discretely supported to the bathroom when they had been unaware of their continence needs. A different person had chosen to spend time in their dressing gown, which had opened as they sat. Staff gently offered to support the person with their dressing needs. When the person declined, different staff tried at different intervals to support them. Another person had fallen asleep in the lounge, their glasses had slipped down their face. A staff member gently woke the person and repositioned their glasses for them. The person then peacefully went back to their afternoon nap.

When people were experiencing periods of confusion, staff responded in a patient and kind manner. Some people who lacked mental capacity to understand that they were living in a care home were asking to go

home. We saw staff respond in a person-centred way to help answer the person's concerns. This helped people to relax, as the response was well received.

Staff recognised when people were feeling unwell, or if they had aches and pains. For example, one person was having difficulty getting up from the chair. A member of staff went to help them and advised them to "take it easy today" after discussing that the person's legs were feeling a little weak. Another person was also not mobilising as well as they would usually. Staff discretely discussed what they could do to support them. The person was encouraged to walk small distances with a staff member, as exercise helped their legs to feel less stiff.

We saw activities, housekeeping, and catering staff interact and engage with people. There was an inclusive and caring culture amongst all staff. Housekeeping staff greeted people with a big smile and said, "good morning". We saw one housekeeper stop to chat with people, including kneeling down to speak to a person at their level while they were sat in an armchair. Also, the cook supported one person by walking with them to their bedroom, and then brought their meal to them in their room.

Staff shared well received humour and banter with people. We saw people respond positively by laughing, smiling, or showing tactile contact with staff. This included staff giggling and smiling broadly with one person while they supported them to have a drink. We were reading the person's care plan while the interactions took place. The interactions and the caring approach we observed, was what had been written in the plan for staff to follow.

Staff adapted their approach to support different people, based on people's preferences and how they communicated best. We saw that one person's care plan stated, "I respond better to staff with a smiley face." All staff greeted this person with a broad smile. Their care plan also stated, "If I'm in a good mood, I will often spend my time singing." We observed the person frequently singing throughout the day.

People were supported to make decisions about their care. We observed one staff member knock a person's bedroom door at 7.30am. Through conversation, it was clear this was the person's preferred time that they wished to be woken. Staff clearly knew the person well as they said, "Shall I run the bath ready for you?" This was the person's preferred morning routine.

People chose where they wanted to spend their time and activities involved people from different parts of the home. We saw people choosing to relax in the 'garden room', a conservatory type area with comfortable seats and views of the garden. The garden doors were open, so those who wanted to spend time outside could do so. There were seated areas and we saw people and their relatives go outside to spend time together. Staff offered people support to "go to a comfy chair", or to "go to the lounge" after lunch, walking with linked arms or holding hands with people who wanted to do so.

Documentation relating to people's personal information and care needs was stored safely. We observed staff accessing and locking secure cabinets in each unit. Staff understood the importance of data protection and confidentiality.

Good

Is the service responsive?

Our findings

People had care plans based on an assessment of their personal needs. We saw that prior to admission an assessment was completed, including details about the person's physical, mental and medical support needs. Following admission, care plans were completed in more detail. This included information about mobility, dexterity and falls, communication, eating, drinking, wound care, sleep and rest, and pain management. The plans were reviewed on a monthly basis to ensure the information remained relevant.

Care plans contained an 'All About Me' document, which was completed with the person and their family, where possible. The document included people's employment history, how they liked to spend their time now, and about their family life. We saw that most people had photographs and a lot of detail recorded. This meant that the document could be used for reminiscence and so that staff could understand what was important to the person.

Although not everyone knew they had a care plan, most people we spoke with knew they had a key worker. A key worker is a member of staff assigned to work with the person to ensure their care plan reflects their needs and preferences. One person told us, "No, I've never seen my care plan, but I do have a key worker."

Daily records were completed each shift by staff. These documented the tasks and activities that the person had been supported with, as well as observations about their general wellbeing. For example, a daily record for one person stated, "[Person] has been in a great and cheerful mood today, she has been laughing and joking with the carers. She has sat in the lounge this morning. [Person] has been supported to the bathroom and to change clothes and has chosen to spend time in her room this afternoon." An overview of the person's wellbeing and social inclusion could be obtained from reading the records.

Information was provided in an accessible format. In people's care plans there were assessments of people's accessible information requirements. For example, if people required information to be spoken to them, provided in braille, or in large print. We saw menus with large print and pictures were displayed in dining areas. The registered manager explained that the complaints policy was available in large print if anyone required it this way.

There was a culture of pro-actively gaining feedback, to promote continuous improvement. We saw that catering audits were used to gather people's feedback about the meal options. The chef completed these by speaking with people after their meal. There were also 'Residents Menu Contribution Meetings'.

Meeting minutes confirmed that people had been spoken with about their choices and preferences. One extract stated, "When speaking with [two people], they expressed that they would like more salad during the day and at tea time, also more jacket potatoes, lighter meals and desserts. I showed them a copy of the summer menu. They both agreed that the menu sounded a lot better and more what they wanted. They were happy and thankful I had listened to their feedback." Another extract referred to action taken in response to feedback, "[Person] said the pastry was hard and she struggled to bite into it. I told her that we had apple pie for the following day and I would change the oven I bake in to see if that made a difference. I

went back to see [person] the following day and she told me I had fixed the pastry problem and she thoroughly enjoyed her apple pie." Feedback from the audits and meetings was used in planning upcoming menus based on people's preferences.

Complaints were investigated, with actions taken recorded. We saw that where complaints had been found to be justified, there were records of correspondence. These showed the service to be open and honest about where they had not been able to meet expectations and the reasons for this. People told us they would feel comfortable raising complaints or concerns. One person said, "If I don't like something, I tell them." Another person told us, "Yes I have raised a complaint a long time ago. I spoke to the [registered] manager and we went from there."

There were two activities coordinators in post and plans to develop the activities provision. One coordinator was employed full time and the other split their role between working as a cook and in activities. The registered manager explained that the home had been without an activities coordinator for two years. We saw that active sessions to promote mobility and dexterity were taking place on the first day of the inspection. On the second day, the morning was spent with reminiscence sessions and in the afternoon, there was activity for baking cheese scones. We saw other people engaged in one to one sessions, including hand massages.

We received mixed feedback from people about activities. Some people told us they enjoyed the activities, whereas others and their relatives felt that the sessions were not of interest. One person told us, "If there's something I want to do, I do it, [the activities coordinator] is very good." Whereas one person's relative explained, "They don't always do the activities that are on the board, let alone anything else. There's not much stimulation here." We saw evidence that the service had spoken with people to gain their feedback to identify what activities they would like to try. These sessions had been included in the programme.

We also received mixed feedback from a healthcare professional and staff about the activities. A visiting healthcare professional told us, "There's a wonderful activity coordinator. They are always doing lots of things here." One staff member explained, "I think they are getting better and there's a bit more for them to do." Another told us, "I think there could be more for the men to do, like gardening or a bit of maintenance. But we do have entertainers come in, they are good."

Signs of deterioration in people's conditions were recognised, and referrals were made to appropriate healthcare professionals. Although there was nobody at the service receiving end of life care, the registered manager recognised where those who had deteriorated in their health may be requiring this support in the near-future. The registered manager and some staff had attended end of life training with a local hospice. There were care plans documenting people's advanced wishes. Each person also had a treatment and escalation plan in place, detailing decisions regarding resuscitation.

Good

Is the service well-led?

Our findings

At our previous inspection in September 2017, we rated this key question as requires improvement. At this inspection, we found that the required improvements had been made and this domain is now rated as good. Action had been taken to address the shortfalls highlighted at the previous inspection regarding the medicines management warning notice, and the quality of care plans.

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

We received mostly positive feedback from people about the registered manager, although some people felt they did not see them that often. Positive feedback included, "I think the home is run ok, very well run in fact." Less positive comments included, "I think the [registered] manager is a woman, but not sure as I have never talked to them. Some things could be better, but I have no complaints." Some people referred to the previous registered manager and were not aware that there had been a change in management.

Relatives told us they knew who the registered manager was and felt they were approachable. Their comments included, "We have both seen and spoken to [the registered manager], they're doing a fine job." Also, "The [registered] manager is doing a good job and so are the staff" and, "I've spoken to [the registered manager], they're very friendly and knows how my mother is and I think they're doing a good job."

The registered manager explained their biggest challenges had been addressing the shortfalls in medicines management; also developing the care plans. They told us that to address the management of medicines they had to work on the staff team culture. The registered manager had developed a positive culture amongst the staff team. Staff felt more confident and clear about the medicines processes than previously. Care plans contained person-centred and important information. The service had received support to continually improve these, with regular quality checks from supporting and operations managers.

There were quality monitoring systems in place, but not all were fully embedded into all areas of the service. This included medicines management, recruitment and training. There had been improvements in the management of medicines and to ensure this was sustainable, we recommend that thorough checks and audits continue. Systems to provide an overview of recruitment files and training needs were in the process of being created.

Audits and quality checks took place. These were completed by the registered manager, staff champions, regional manager, and the organisations quality team. The service also received a quality monitoring visit from the local authority commissioning team as part of their routine work. We saw that audits were completed for areas such as infection control, care plans, medicines and health and safety. The audits were thorough and were based on the CQC Key Lines of Enquiry. Where concerns were identified, actions and

realistic timeframes were set for their completion.

Meetings took place with people, relatives and staff. These were either general meetings, or specific to certain aspects of the service. For example, catering or activities. There were also annual surveys to gain people's feedback. We saw the results of the survey were displayed on a notice board for people, relatives and visitors to see. These related to 2017 and the 2018 survey was in preparation ready to be sent out.

There were staff champions in place, for areas such as infection control, medicines, pressure care, dementia care, and falls. The registered manager explained that some staff had particular areas of interest and were supported to take on the role of champion for those areas. Champions completed audits and monitored progress for example where people were losing or gaining weight. This helped to create a culture of strong leadership at the home, with staff invested in driving improvements.

Staff spoke positively about the support they received from the registered manager. Their feedback included, "They are really approachable", "I'd say the [registered] manager is firm but fair", and "They are focussed and on the ball, if they need to have a word with you they will always make sure it is discreet and professional, we go into the office and I appreciate that."

Staff told us the registered manager was a visible presence within the home. Their comments included, "The [registered] manager gets around the home. They will always try to iron out any problems." Also, "We see [the registered manager] around a lot. They are very approachable and will mingle with the residents."

There was a vacant post for a head of care, to act as a deputy to the registered manager. The registered manager explained that they had felt supported by their team while the vacancy was being recruited for. They explained, "I wouldn't have been able to do it without such a good team. They embrace changes. We have a good laugh together and it helps keep them motivated."

The registered manager told us, "I am a big believer in motivating staff and empowering them. Not all staff work for money, they do it because they love what they do. If the staff are happy, they will deliver good care. I also will do the job of the care staff and help when there are any struggles, I want to help them."