St Joseph Care Ltd

St Joseph's Convent Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 January 2018 and was unannounced.

St Joseph's Covent Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Joseph's Covent Nursing Home accommodates up to 46 people in one adapted building. At the time of this inspection there were 44 people using the service.

At the last inspection the service was rated good. At this inspection the service was rated requires improvement. This is the first time the service has been rated Requires Improvement"

There was a registered manager in post at the time of 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.

People were not always protected from avoidable harm because unexplained injuries had not been investigated and reported to local safeguarding authority as required. Action had not been taken to reduce the likelihood of similar injuries occurring again. You can see what action we told the provider to take at the back of the full version of the report.

Risks were assessed however risk management plans in place were not consistently followed.
People told us they received their medicines as prescribed however we found some issues which showed that medicines were not always managed safely and people did not always receive their topical creams as intended.

Staffing levels were sufficient to meet people's needs and staff had their suitability to work in a care setting checked before they began working with people. Premises were kept clean and tidy and people were protected from the risk of infection.

People's needs and choices were assessed and the assessment process was suitable. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People were supported by trained staff however some staff needed more support to check they had understood the training they received. Staff received regular supervision and felt supported in their roles.

The environment was adapted to meet people's needs and there were plans in place to improve the decoration of the home. There was a good choice of food, which people enjoyed and they received support

to meet their nutrition and hydration needs. Healthcare professionals were consulted as needed and people had access to a range of healthcare services.

Staff were kind, caring and compassionate with people. People were supported to express their views and encouraged and supported to make their own choices. People were treated with dignity and respect and their independence was respected and promoted.

People's diverse needs were not always fully assessed and planned for to ensure they received fully personalised care. People had access to activities though some people felt they were repetitive.

People received dignified support, in line with their wishes at the end of their lives, where this was required.

People knew how to complain and concerns were acted upon though plans were not always put into place to reduce the likelihood of the same concerns arising again.

Systems and processes in place to monitor the quality and safety of the service needed some improvement, as the issues we identified during the inspection had not been identified through these processes. However, the registered manager was receptive to feedback and contacted us following the inspection to tell us about improvement they had already started to make.

The registered manager was freely available to people, relatives and staff, along with the provider. People, their relatives and staff were involved in the development of the service and they were given opportunities to provide feedback that was acted upon.

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 consistently safe.

Incidents of potential abuse or avoidable harm were not always recognised, reported and investigated to ensure people were protected from harm and plans were not always put into place to minimise on-going risks to people. Risk management plans were in place though these were not always followed.

People told us they received their medicines as prescribed but we found some issues which meant that medicines were not always managed safely and improvements were needed to ensure that people got their topical creams as prescribed.

There were enough safely recruited to meet people's needs and people felt safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs and choices were assessed and staff received training and support though some staff needed more support to ensure they understood the training they had received.

People consented to their care when they were able to, in line with the law and guidance.

There were plans in place to improve the environment to make it more suitable to people's needs.

People enjoyed the food and were provided with support to maintain a balanced diet and had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who knew them well.

People were offered choices and their views were listened to.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's diverse needs were not always fully assessed to allow staff to deliver fully personalised care.

People had access to activities and visitors were welcome at any time, though some people found the activities repetitive.

People knew how to make a complaint and felt comfortable to do so. Complaint were responded to in line the provider's policy though plans were not always in place to ensure the same concerns did not arise again.

People were supported in a dignified way at the end of their life and their comfort was assured.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor quality and safety of the service had not identified all of the issues we found during the inspection.

People, relatives and staff felt the management were approachable and supportive and they felt involved in the development of the service. People's feedback was gathered and acted upon.

The service worked with partnership agencies and other professionals to try and improve outcome for people who used the service.

St Joseph's Convent Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 January 2018 and was unannounced. The inspection team consisted of two 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.

We used the information we held about the service to formulate our inspection plan. This included information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. These include information about safeguarding concerns, serious injuries and deaths that had occurred at the service. We also considered feedback received from the local authority commissioners and safeguarding adults' team about the services provided at St Joseph's Convent Nursing Home.

We spoke with twelve people who used the service and four relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with ten members of staff including a nurse, cook and domestic staff and a visiting social care professional. We observed how care staff interacted with people in communal areas and looked at five people's care records. We spoke with the registered manager and deputy manager.

We also looked at records relating to the management of the service. These included five staff files, training

records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People were not consistently protected from avoidable harm. We found that some unexplained injuries such as bruising and skin tears had not been investigated and/or reported as a safeguarding concern. For example, one person's records showed that they had a skin tear to their leg and the cause was unknown. A photograph had been taken which showed a significant wound to the person's leg. There were no records that showed this concern had been investigated or reported to the local safeguarding authority for investigation. This meant the service could not be sure how this injury had occurred as no action to investigate had taken place and therefore no plans were put into place to reduce the risk of a similar injury occurring again. Another person's records showed that they had bruising to their face. There was no explanation as to the cause of this and it had not been raised as a possible safeguarding concern.

Some staff were able to tell us how they would recognise and report potential abuse and told us they had received training to help them to do this. However, we found there had been occasions when appropriate action had not been taken, though people's family had been informed of the injuries. We spoke with the registered manager who was unaware of these incidents. A system was in place whereby an incident form should be completed and the registered manager would then review this and take any necessary action. However, incident forms were not consistently being completed which meant that the systems and processes in place did not adequately safeguard people from potential abuse and avoidable harm.

The above evidence shows that people were not always safeguarded from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we received assurances from the registered manager that a new system had been implemented to better safeguard people from the risk of abuse and that staff had received further communication in relation to safeguarding adults' procedures.

People's risks were not consistently assessed and managed to support them to stay safe. The person who received a significant skin tear had no plan in place to help reduce the risk of this occurring again. The registered manager told us the skin tear could have been caused during the person being supported to move. However their risk management plan in relation to moving had not been updated to reduce the risk of this occurring again. We found that when risks had been assessed, there were clear and detailed plans in place for staff to follow to minimise risk. For example, one person was assessed as being at very high risk of developing pressure sores. There was a clear and detailed plan in place for staff to follow which included the application of a barrier cream daily. However, when we looked at their topical creams records, we saw there was conflicting information in place about how often the barrier cream should be applied and there were many gaps in the records which meant the person may not be receiving the cream as often as required. We spoke with staff who told us the cream was prescribed 'as and when required' but this conflicted with the information recorded in the risk management plan. This meant that risk management plans were not always followed to reduce identified risks.

When accidents and incidents had been reported within the home appropriate action was taken to reduce

the lilklihood of the reoccurring again. We looked at the records of incidents at the home and saw that one person had displayed some behaviour that challenged staff. There was a clear plan in place which guided staff on how to support the person. Staff had been issued with a training booklet to help them understand and manage the person's behaviour and a referral had been made for specialist advice and support to ensure the person was safely and appropriately supported.

People told us they received their medicines as prescribed. One person said, "I take 17 tablets a day, the nurses give them to me on time. They ask me if I need paracetamol." However, we saw some practices which showed that medicines were not always managed safely. We observed that one person was given their tablets and the staff member walked away to sign the Medicines Administration Record (MAR) before ensuring the person had swallowed their tablets. The person then voiced confusion about whether they had received their tablets, which meant there was a risk that they may not have taken their medicines, despite it being recorded that they had. We observed that the medicines fridge was left unlocked and unsupervised which meant there was a risk it could be accessed by anyone, which was an unsafe practice. Some people were prescribed 'as required' medicines. There were protocols in place to guide staff on how to administer these medicines; however these lacked detail to ensure a consistent approach in administering the medicines. For example, one person was prescribed pain relief medicines on an 'as required' basis but their protocol did not clearly explain to staff how the person communicated that they were in pain. This meant there was risk that they may not consistently receive their medicines as it was required and prescribed. We also found that one person's MAR did not match with the 'as required' protocol that was in place so there was a risk they may not receive the medicine as it was prescribed. These issues showed that medicines were not always safely managed.

We spoke with the registered manager about these issues and they told us they would take action address the issues. Following the inspection they told us they told us they had reviewed people's 'as required' protocols to ensure they were accurate and detailed, they had introduced spot checks to ensure the medicines fridge was locked and they had spent time with relevant staff looking at the home's medicines policy to ensure it is consistently followed. This meant the service was taking action to make improvements when issues had been identified. We could not yet assess whenter these improvement were sufficiently embedded into practice and sustainable within the home.

People and relatives told us there was usually enough staff to keep people safe and meet their needs. One person said, "I ring the buzzer when I want to go to bed, I don't wait long." Another person said, "The buzzers are answered promptly generally." We observed that people received prompt support when they requested it in communal areas. For example, one person asked to move to another room. A staff member promptly arranged another member of staff to assist them, as the person needed two staff to support them to move safely. However, some people were nursed in bed and unable to use their call bells and although a system of regular checks was in place, we observed that often, corridors were unstaffed and people may not have prompt access to the support they needed. We fed this back to the registered manager who said they would consider staff deployment.

Staff told us there was enough of them to meet people's needs and that when staff from an agency were used, they only came from one particularly agency to try and ensure consistently. One staff member said, "There's always enough staff, we only have occasional sickness. We use one agency that has a policy to make sure staff are well trained." The registered manager told us and we saw that they regularly assessed the level of needs of people who used the service and this informed the number of staff on duty. This was called a dependency tool and helped to determine the number of staff needed to meet people's needs. We saw that the number of staff on duty exceeded the number recommended by the tool. The registered manager said they did this as the building layout meant that more staff were needed. This meant that the

registered manager and provider had ensured there were enough staff available to meet people's needs.

People received support from safely recruited staff. Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people. We saw staff provided two references. The provider checked to ensure staff were safe to work with vulnerable people through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions. This meant safe recruitment procedures were being followed in relation to the employment of new staff.

People told us they felt safe and we saw that people were smiling and happy when interacting with and receiving support from staff. One person said, "I feel safe here in my own room. I'm happy here." Another person said, "I feel safe and looked after here. I could not have better care, I'm very happy."

People and their relatives told us that the service was clean and tidy. We observed that all areas of the home and equipment looked clean and hygienic and saw domestic staff carrying out their duties throughout the inspection. Laundry, domestic cleaning and 'wash up' staff were employed separately to care staff to help prevent the spread of infection and manage hygiene. A member of domestic staff told us they had received training to help them understand their role in relation to infection control and hygiene. They told us, "I've had a lot of training both face to face and online modules. It was really good actually; there were lots of things I didn't even realise so I'm well equipped now." Staff understood the importance of infection control, and we observed them using protective clothing that was readily available to them. We saw that people were 'barrier nursed' when it was suspected they had an infection, to prevent the infection from spreading. The registered manager told us there was an infection control lead nurse at the home who completed audits and we found these were effective. This meant people were protected from the risk of infection and cross contamination.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us and we saw that people's needs and choices were assessed to ensure they could be effectively met by the service. One relative said, "[Registered Manager's name] visited us at home and went through everything, we talked about [my relative's] needs and choices. They were very forward thinking and so sensible and planned everything in a problem-avoiding way." We saw that people's needs assessments were holistic and included consideration of relevant guidance. For example, we saw that a person's skin care plan referred to the NICE (The National Institute for Health and Care Excellence) guidelines for pressure ulcer prevention and management to ensure that effective outcomes were achieved. However, we found one person's needs and choices had not been reassessed when required and this could have had a major impact on their care and treatment choices. We saw they had a DNAR form in place which recorded a medical diagnosis that had later been found to be inaccurate. A DNAR form is a document issued and signed by a doctor, which tells a medical team not to attempt cardiopulmonary resuscitation. The service had not requested a doctor review the DNAR form following the misdiagnosis which meant there was a risk that the person may not receive the medical attention they required. We fed this back to the registered manager who arranged for a doctor to review the DNAR form. Aside from this one example, we found that the assessment process was appropriate.

People's consent to care was sought in line with legislation and guidance. One person said, "Staff ask my consent and explain everything." A relative told us, "[My relative] is able to make their own decisions but staff explain everything to them. Recently [my relative] didn't want to wear a clean jumper, staff hung around to catch us and explain this when we visited." The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We observed that people were asked for their consent before care was carried out and staff supported people in line with the principles of the MCA. When people lacked mental capacity about certain aspects of their care, we saw that a decision specific test of their capacity was carried out, in line with the MCA. We saw that decisions were made in people's best interests when required and these accurately recorded why the decision was in the person's best interests and was shared with staff to ensure that people's rights were protected.

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 found that people had been referred for a DoLS authorisation when this was required. 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. We found that staff were not always aware when people had a DoLS authorisation in place and staff did not fully understand the requirements of the MCA. Although the service were working in line with the current legislation and guidance to ensure that people's rights were protected, care staff needed more support to understand the MCA and what this means for people who use the service.

Staff were supported to develop the skills and knowledge to provide effective care, however their competency and understand of training was not always checked. Staff told us they were provided with the training and support they needed to carry out their role effectively. One staff member said, "We have regular training updates. We have mandatory training like fire safety and moving and handling but also courses in catheter care and skin care. They are not mandatory but you are encouraged to widen your knowledge. Staff here know what they are doing and we learn all the time." A new role of care coordinator had been developed and part of this role was to train and supervise new staff to ensure that a thorough induction was completed and there was the opportunity to ask questions and learn from an experienced member of staff. Staff felt well supported in their roles and had access to regular supervision, appraisal and support from the registered manager and deputy manager. One staff member said, "I am absolutely supported. I have supervision and appraisal and they provide ways for us to grow, they embrace that." The registered manager told us that during appraisals, some staff had requested further training in End of Life care and we saw this had been resourced and planned by the registered manager. This showed that staff were supported and encouraged to develop their knowledge and skills in order to provide effective care. However, some staff needed more support to ensure they understood their responsibilities under the MCA and safeguarding adult's procedures to ensure people were supported by suitably skilled, supported and trained staff.

We saw that the environment had been adapted to help meet people's physical needs. There were bathrooms with assisted showers, shower chairs and handrails and some people had their own en-suite bathrooms. One person said, "I have a nice room on the ground floor with my own bathroom." There was a lift so that people could move easily between floors. The building is large and the registered manager told us plans were in place to make use of some space that was not currently in use and that people who used the service were being consulted on this. There were plans in place to improve the decoration of the home as some areas were dated. A painter had been employed and we saw they had started work on the corridors to help make them more bright and fresh. People who used the service had requested a new bathroom with a special assisted bath and we saw that the registered manager, with support from the provider, was taking action to put this into place. This showed that the registered manager and provider had considered people's needs and were in the process of making improvements to the environment.

People told us they enjoyed the food at mealtimes. One person said, "The food on the whole is very good, like a hotel." People had choices and specialist diets were catered for. One person said, "The food is very good, I am a vegetarian, the cook is very good and I normally have whatever I want." People told us and we saw that when they required their food mashed or pureed because of risks of choking, this was provided and presented in an appetising manner. People enjoyed their mealtime experience and were offered a choice of wines, sherry and a variety of juices to accompany their meal. The cook confirmed that people were able to have choices and that food was fortified to increase the calorie intake for people who were at risk of losing weight. We observed the cook offered people choices and that they had a good relationship with people who used the services and knew their nutritional needs, likes, dislikes and preferences. This showed that people were supported to eat and drink, in order to maintain a balanced diet.

Staff told us that they attended a handover session at the beginning of each shift, which ensured that they were able to provide a safe and consistent level of care to people. One staff member said, "The team leaders organise the day and where staff are based. We have handover each morning which updates us on how people are; it depends on how people are each day as to where staff are delegated to." The handovers ensured that any risks or changes in people's needs were highlighted and that people had the support and care they needed dependent on their changing needs each day. This showed that the service ensured that people received consistent care within the service.

People told us and records confirmed that they were able to see health professionals when they needed to.

One person said, "The doctor calls when needed. In fact today I'm seeing a nurse practitioner to have a look at my eye as the nurse here is a little concerned about it. The optician and chiropodist visit. The staff accompany me to hospital appointments." Another person said, "If needed, I see my doctor, optician and chiropodist." The registered manager told us that the General Practitioner (GP) visited the home weekly and an Advanced Nurse Practitioner visited the home twice per week to support people to manage their health needs. A visiting social care professional told us, "Staff here work well with the therapists (Occupational therapists and Physiotherapists). One person was successfully supported to return to their home following rehabilitation here. They always contact us when needed and refer to other professionals when needed." Records showed that referrals were made for professional assessment and advice when needed and people had access to professionals including dieticians and tissue viability nurses. This meant that people were supported to access health professionals to maintain their health and wellbeing and advice sought was followed by staff.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and the way staff treated them. Comments included, "I'm very happy, the staff are very pleasant", "The care is very good. I get whatever I ask for. The staff are kind and helpful" and "I'm very happy with my care. I feel so happy here I don't want to go home." Relatives told us that people were treated with kindness and respect. One relative said, "When [my relative] moved in, my first impression was that there was a lot of staff. Every single one of them introduced themselves and shook [my relative's] hand. What a good start!" A social care professional said, "People are happy with the care here. It's one of the homes you enjoy coming to, it's very good. It's light, airy and clean and there's a lovely feel. Certain homes you look forward to coming to and this is one of those." We observed that staff treated people with kindness and compassion. For example, we saw staff asking people if they were comfortable and engaging in chat about things people were interested in. We saw one staff member say, "Can I pop this blanket on you [Person's name] to keep your legs warm?" The person said, "Of course you can" and smiled at the staff member. This showed that people were treated with kindness by staff who took an interest in their wellbeing.

People told us that they were given choices about their care and how they spent their time. One person said, "I was asked if I wanted to go to the lounge today but I don't feel like it so I'm staying in bed. Staff wash me in bed, they keep me clean and fresh. The care is wonderful. Staff are so caring." We saw that people were given choices throughout the day by staff who were patient and listened to what people wanted. We heard staff asking people in a way that promoted their understanding and repeated questions if people hadn't heard or understood the question. People responded well to the way staff interacted with them and staff had a good understanding of how best to communicate with people. One person said, "My eyesight is very bad and the staff will do anything for me." Staff told us they offered people choices and listened to their views. A staff member said, "I always listen to them. I always ask, 'is this OK?'" The cook told us, "People can have what they like. It could be their last meal so it's important, food is important to people." People had access to advocacy services if they required this and we saw an easy-read advocacy leaflet was displayed on the notice board. This showed that people were supported to express their views and be involved in choices about their care.

People's privacy and dignity was maintained. We observed staff ensuring that doors were closed before supporting people to use the toilet and knocking on people's bedroom doors before entering. Staff told us how they respected people's dignity and privacy. A staff member said, "I always make sure they're covered up during personal care and the doors are closed to protect their privacy." People were able to access their bedrooms whenever they chose to and could have privacy by themselves or with their visitors. People looked well presented in clean and matching clothes which upheld their dignity. The service had members of staff who were 'dignity champions' who have pledged to uphold people's dignity and encourage this of other staff members. We saw there was an invite to national dignity day at the local college displayed on the notice board, which showed the service had a commitment to promoting people's dignity.

Requires Improvement

Is the service responsive?

Our findings

We found that people's diverse needs were not always fully assessed and planned for and this important information was not always available to staff. For example; one person's records we viewed contained information about their cultural background. However, when we spoke to the person, they told us this information was incorrect. The person's cultural needs had not been assessed and planned for in order to allow staff to provide a personalised service to them. When we spoke with the registered manager about this, they told us the cook had previously catered for the person's cultural dietary needs despite this not being recorded in their care plan; however this was the only area of their cultural needs that had been addressed. We saw examples of people's religious needs having been assessed and planned for and some people accessed the onsite chapel in order to practice their faith. One relative said, "The chapel onsite is very important to [my relative]." However, we found that people's other diverse needs such as sexuality had not been considered at the assessment stage and people's sexual orientation were not detailed in the care records. This meant that improvements were needed to ensure people were receiving a fully personalised service in all aspects of their life.

People and their relatives were involved in some aspects of their care. We saw that a 'This is Me' assessment was completed and provided staff with easily accessible information about the key areas of the person's needs and preferences. This document included information about life history and social needs though some life history information was limited. People's communication needs were met in line with the Accessible Information Standard. Staff told us they would speak to people or their families to get know their likes and dislikes. However, one person told us that whilst they did not mind receiving personal care from a male member of staff, they had not been asked about their preferences. This meant that improvements were needed to ensure that people were involved in their care planning as much as possible to ensure care was personalised and responsive to their needs.

People told us they had access to activities within the home and had the choice of whether to participate or not. One person said, "Sometimes I like to stay in my room and sometimes come to the lounge to join in the activities, I can do whatever I choose." Some people told us they enjoyed all of the activities however some people said that the activities were repetitive. One person said, "I attend all the activities but it's very boring as it's the same things over and over." We saw that people enjoyed listening to a singer in the morning and some people participated in Popmobility in the afternoon. Popmobility is a form of exercise that combines aerobics in a continuous dance routine, performed to pop music. A monthly newsletter was completed and issued to all people who used the service, this included minutes of the monthly residents meeting and the activities diary as well as other information. We saw that people had copies of this in their bedrooms and one person said, "I see the monthly newsletter and know when the church services are held." People and relatives told us and we saw that visitors were welcome to the home and were able to make their own hot drinks, which encouraged people to maintain relationships that were important to them.

People and relatives knew how to raise concerns and complaints and felt able to do this when required. One person said, "If I had any concerns I'd speak to the nurse or the carers. I've never had to make a complaint but I know how to." Information on how to make a complaint was available to people and we saw that

complaints made were recorded and dealt with in line the provider's policy. We found that when a complaint had been made, action was taken to address the concerns and the complainant received a written response. However plans were not put into place to reduce the likelihood of the same concerns arising again. This showed that people's concerns and complaints were listened to but not always used to improve the ongoing quality of care.

At the time of our inspection, no one was receiving end of life care. However we found that advance care plans were in plan and people and their relatives had been consulted to gain their wishes and preferences for end of life care including details such music the person would like to be played, visitor preferences and the person's wishes after their life had ended such as burial or cremation. We saw that the home was operating a 'purple bow scheme'. This scheme meant that a purple bow would be displayed at reception and at the person's bedroom if they were receiving end of life care. It let people know to be quiet and respectful and this information was displayed clearly for all visitors. A funeral procession was operated when a person had passed away, whereby an announcement would be made for staff to congregate and pay their respects for the person. This showed that people were supported to have a comfortable and dignified death when the time came.

Requires Improvement

Is the service well-led?

Our findings

There were systems and processes in place to assess and monitor the quality and safety of the services provided, though these were not always effective. For example, a medicines audit had been completed in December 2017 but this had not identified the issues that we found with medicines during the inspection. We found that accidents and incidents were analysed regularly by the registered manager and action was taken to minimise risks when required. For example, we saw that people had been referred to the falls team when required and assistive technology had been provided to people following an analysis of falls. However, staff were not always completing incident forms when required and this meant the registered manager did not get to know about all accidents and incidents that happened at the home. The staff member had recorded the incident in daily records rather than an incident form. There was no system in place for the registered manager to routinely review the daily notes so the issue had not been identified. This meant that the quality assurance systems in place were not always effective.

Following the inspection the registered manager informed us how they had made changes to the systems and processes in place to ensure that all accident and incidents were identified and acted upon to drive continuous improvement. A communication diary is now in place for nursing staff to report concerns such as bruising/skin tears alongside documenting on the provider's electronic care planning system. The registered manager is able to review the communication diary daily to ensure that any incidents are identified and acted upon as required.

We saw that staff had received training. However, we found that there was not a system in place to monitor their understanding and competency after they had undertaken training. For example; staff told us that they had undertaken safeguarding training, but we found that some instances of unexplained bruising had not been reported or investigated as required. Staff had received training on the Mental Capacity Act 2005 (MCA) however, staff we spoke with were unable to explain what the MCA meant for people who used the service and how the Deprivation of Liberty Safeguards (DoLS) was used to protect people using the service. This meant that there was risk that people may not receive safe and good quality care because staff competency was not effectively assessed.

There was a registered manager in post who was not the registered manager at the last inspection. The registered manager understood their responsibilities and was supported by the provider to deliver what was required. The registered manager told us, "The owner lets us make a difference." It is a legal requirement that a provider's latest CQC inspection rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We saw that the rating of the last inspection was on display. Notifications were received of incidents that occurred at the service, which is required by law. These may include incidents such as a death of a person who uses the service or events that stop the service running as usual. The registered manager had notified us when the lift at the home was broken and provided details of what action was being taken, they were open and transparent in sharing information about these incidents.

People, relatives and staff told us that the registered manager and deputy manager were approachable and

supportive. One person said, "I know the manager and the deputy who sometimes comes into my room for a chat." People and relatives consistently told us they knew who the manager was and that they often saw them around the service. Another person said, "The manager calls in sometimes to chat, she also sometimes puts her apron on and helps out." A staff member said, "The manager and deputy manager are great. The owner comes in every week too and has a lot of input. We have staff meetings to communicate any changes and we get the chance to feedback too." This showed that the registered manager and provider promotes an open and positive culture within the home.

People, relatives and staff were engaged and involved in the development of the service. There were regular resident and relatives meetings which gave people the chance to share their feedback on the quality of the service provided. We saw that feedback was acted upon, for example, people had requested that residents fund money be spent on a new bathroom and we saw the registered manages had started to make enquiries about this. We also saw that residents had requested the option of sherry being served and meal times and we that this was now served. A copy the meeting minutes were issued to all people who used the service to ensure that actions and changes were communicated. One person said, "I've been invited to monthly residents meetings but I've usually got visitors so haven't attended but I've seen minutes of what's been discussed". Staff were actively involved in the development of the service and we saw that regular staff meetings took place where opportunities to share any concerns and feedback were available. Staff told us they felt supported in their roles and comfortable to approach the management with any issues. Staff were encouraged and supported to lake lead roles within the home including an infection control lead nurse and another staff member had been supported to develop the role of care coordinator as the management recognised their strengths in working with new staff members. The service also facilitated a placement for a student nurse from a local university and were looking to continue this as a development opportunity for staff in providing support to the student and building stronger links with colleges and universities. These examples showed that the provider and registered manager engaged people and staff in the development of the service.

We found the registered manager and staff team had systems in place to provide consistent care and work collaboratively with other agencies. This included engaging with a range of health professionals such as doctors, tissue viability nurses, physiotherapists and occupational therapists. The registered manager told us they had good relationships with external professionals and had good support from local doctors and advanced nurse practitioner. We saw that the home had participated in the Nursing Home Project with an aim of improving care for people who use nursing home services and received positive feedback from the lead nurse involved. The home also participated in a number of research projects to help improve the experiences of people who used the service. This meant the management were actively working with partnership agencies and other professionals to improve outcomes for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to protect people from the risk of avoidable harm and/or abuse because unexplained injuries had not been investigated or acted upon to ensure people were protected.