Hayes Cottage Nursing Home Limited

Hayes Cottage Care Centre

Inspection report

Grange Road
Hayes
Middlesex
UB3 2RR

Tel: 02085732052
Website: www.hayescottage.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Hayes Cottage Care Centre is a nursing home providing personal and nursing care for up to 52 adults. The home consists of three units across a ground and first floor. One unit focused specifically on providing end of life care to 10 people. At the time of the inspection there were 48 people living at the home. The home is operated by Hayes Cottage Nursing Home Limited.

People's experience of using this service
Staff were caring, treated people with respect and promoted their dignity and privacy. People and relatives said they felt people were safe and their care needs met.

There were systems in place to monitor the quality of the service, recognise when improvements were required and to take action in response to these. However, the service had not consistently kept up to date records in respect of some people's care and the management of the service.

We have made recommendations about supporting people with their nutrition and dehydration and maintaining records.

There were systems in place to monitor the quality of the service, recognise when improvements were required and to take action in response to these. However, these had not identified or addressed the areas for improvement we identified.

People were supported to be healthy and to access healthcare services. Staff worked with other agencies to provide people with joined up care. People received their medicines as prescribed.

People's assessments and care plans set out how staff should support people, along with some personalised information about people, their preferences for their care, and their communication needs.

People were supported at the end of their life to have a comfortable and dignified death.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff arranged and supported people to engage in a variety of activities that were meaningful to them and people could choose how they spent their time.

People and their relatives knew how to raise concerns or complaints and were confident they would be listened to. The provider sought feedback from people, relatives and staff and used this to develop the service.

There was a clear management structure in place and staff said the managers were approachable. Staff received induction, training and supervision and most felt supported in their roles.

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

Rating at last inspection:
The last rating for this service was good (published 9 August 2017).

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Hayes Cottage Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector, an assistant inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information about important events the provider had notified us about that had happened at the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and two visiting relatives. We spoke with a variety of staff on duty including nurses, care staff and catering staff. We met with the registered manager, deputy manager, nominated individual and financial director. We also spoke with a four adult health and social care professionals who visited the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked the care records for 10 people, medicines support records, and a variety of records relating to staffing and the management of the service.

After the inspection
We continued to seek further information and clarification from the registered manager to validate evidence found. We spoke with four health and adult social care professionals who had worked with the service.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

● Nurses and managers completed risk management plans for people to reduce risks to their safety and well-being. The plans provided basic directions for staff on how to mitigate the risks to people. For example, supporting people with their mobility, skin integrity and bowel care. Records of daily care showed staff helped people in bed to turn regularly to avoid damage to their skin, in line with their plans. People's turning charts recorded when staff moved them, but they did not always record the frequency at which people needed to turn. We raised this issue with the registered manager so they could address this.

● There were appropriate fire safety arrangements. There was a fire safety risk assessment in place, maintenance staff checked the fire safety systems weekly, equipment such as extinguishers were checked regularly, and staff practiced periodic fire drills. Staff had completed fire safety training and knew what to do in the event of an emergency.

● The maintenance manager conducted a variety of checks to monitor and maintain a safe environment for people. These included making sure there were appropriate domestic gas and electric utility arrangements in place. They conducted weekly testing of water temperatures, window restrictors, lighting, people's wheelchairs, bed rails and mobility equipment. The registered manager audited these checks on a monthly basis.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems in place to safeguard people from the risk of abuse and people told us they felt safe. One person said, "They keep an eye on me and so I feel safe."

● Staff knew how to recognise and respond to safeguarding concerns and report these to the managers. Staff also knew about escalating such concerns to other external agencies if required. For example, staff would inform local statutory services if a person moved into the home with pre-existing pressure sores. Staff had completed safeguarding training.

● The registered manager promoted staff awareness about safeguarding during staff inductions, supervisions and team meetings.

Staffing and recruitment

● The provider arranged for enough staff to be on shift to support people to stay safe.

● People we spoke with all told us staff usually responded promptly to their call bells so they could get help when they needed. We also observed staff respond to quickly to people's call alerts when they sounded. People were supported to have their call bells with them near their beds or when they were out of their bedrooms. The registered manager said when they were at the home they checked staff responded to calls bells in a timely manner. The current call system could not monitor the time it took staff to respond to people's alerts. The registered manager told us the provider planned to introduce a new system that would

enable this functionality.
● People and staff told us they felt there were enough staff on shift to meet people's needs. One staff member said, "There is enough staff here, we are like a family." Staffing rotas for the two months prior to our visit indicated the provider maintained sufficient numbers of nursing, care and domestic staff to support people. The rotas showed the provider used regular bank staff to cover any vacant shifts and hardly ever engaged temporary agency staff for this. This meant people were supported by staff who could be familiar with their care needs and the service's systems. Healthcare professionals also told us they felt people received continuity of care from regular staff.
● Recruitment records showed the provider had completed necessary pre-employment checks to make sure so they only offered roles to fit and proper applicants.

Using medicines safely
● There were processes in place to ensure people received their medicines as prescribed. People's care plans provided information about their prescribed medicines. There were protocols in place to guide staff on when they should support a person to take 'when required' medicines. These medicines are those given only when needed, such as for pain relief or in an emergency.
● Nursing staff supported people to take their medicines, had received training in providing this support and the provider had assessed their competency to do this safely.
● People's care plans provided information about their prescribed medicines. There were protocols in place to guide staff on when they should support a person to take 'when required' medicines. These medicines are those given only when needed, such as for pain relief
or in an emergency.
● Medicines administrations records (MARs) provided basic information for the safe administration of people's medicines and staff had completed these appropriately.
● There were systems for ordering, handling, storing and disposing of medicines, including controlled drugs. The registered manager had liaised with other agencies to address recent issues regarding the home receiving people's prescribed medicines in good time from dispensing pharmacists.
● We saw the registered manager and local pharmacist conducted regular audits of medicines support and the registered manager took action to address issues these checks found. Healthcare professionals told us when they changed people's medicines prescriptions staff responded to this quickly to make sure people continued to receive their medicines as prescribed. For example, when people needed medicine to help control pain they might experience. Professionals also said they are had observed medicines being stored appropriately as well.

Preventing and controlling infection
● There were arrangements for preventing and controlling infection.
● People who needed to use mobility equipment frequently to move, for example from their bed to a chair, had their own slings for this, which promoted infection prevention. However, some people who did not need such support regularly had to share a sling with another person. We discussed this with the registered manager who explained they had systems in place to ensure slings were cleaned. Also, they had recently purchased and were ordering more new slings, so all people had their own slings to use.
● Staff told us they had received training regarding infection control and we saw evidence of this. Staff had access to protective equipment like gloves and aprons to prevent and control infection. We saw hand sanitiser was available to people throughout the home, including in the kitchens, and we saw staff using this. We saw up to date information for staff regarding people experiencing infections overseas.
● The home environment was generally clean, there were no unpleasant odours and we saw domestic staff cleaning areas when we visited. The registered manager conducted monthly infection control audits. They used these to check staff were observing appropriate hand hygiene practices, clinical waste was being

disposed of properly and areas around the home were being kept clean.
● The local environmental health officer had inspected the home in the month before our visit and awarded the service a maximum five stars Food Hygiene Rating. The kitchens were clean and tidy when we visited. We saw the catering team had systems in place for making sure the kitchen areas were cleaned regularly and food was labelled and stored correctly. Cooked food and fridge/freezer storage temperatures were checked and recorded appropriately.

Learning lessons when things go wrong
● The provider had procedures in place for responding to and learning from incidents and accidents.
● Staff recorded what had happened when incidents or accidents occurred and the actions taken in response to them. We saw the registered manager maintained a log of these records and reviewed them regularly to identify learning to reduce to risk of incidents happening again. For example, obtaining alternative needles for nursing staff to use when helping measure a person's blood sugar levels so there was less chance of staff injury when using them.

Good

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has stayed the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

- The provider did not always ensure there were clear arrangements in place to manage the risks associated with poor hydration some people may experience.
- Some people's care records indicated staff recorded how much they drank and ate. We looked at recent daily fluid intake charts for two people. These charts did not record how much staff needed to support the people to drink each day and sometimes staff had not tallied up the amount of fluids a person had taken that day. People's care plans did not state a target amount for each person to be supported to take daily or the action to take in response to people's low intake over a number of days.
- We discussed this with the deputy manager. They explained people were receiving end of life care and so their comfort rather than fluid intake was the priority aim of their support and nurses checked people's intake records daily. However, the intake charts we checked for these people did not indicate a nurse had reviewed them or if actions were taken or considered in response to the records.

We recommend the provider considers current guidance on recording the regular monitoring of people at risk of poor nutrition and dehydration and takes action to update practice accordingly.

- We raised the issue regarding the use of some people's fluid monitoring charts with the registered manager so they could address this.
- The catering staff were familiar with people's dietary requirements and catered to these. For example, when people were diabetic or could not have dairy products. The provider also assessed, recorded and met people's cultural food preferences.
- People said they liked the meals they were offered and were always given a choice. We saw there were printed menus available for people to choose from, including gluten-free alternatives. People told us their food met their choices and needs. One person said, "They sorted out my food, so I was happy with that as I have dietary requirements." Another person told us they were able to choose when they wanted to eat their meals in their room or in the dining room.
- We saw lunchtimes were an unhurried experience and people were given time to eat their food. People did not have to wait long for their meals and there were enough staff to help people to eat. We saw the registered manager also helped people to eat. Staff treated people respectfully and chatted with them while they supported them with their food. People were supported to drink during lunch and there was a choice of drinks available to them. We saw some people were supported to use adapted cups, so they drank safely.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care needs were assessed before they moved to the service. Assessments identified people's

needs, past medical history and included information about things important to the person. For example, particulars about any conditions they lived with, food preferences, known allergies and some of their previous life history. People's relatives had been involved in discussions about people's needs, where appropriate.

● The service also supported people who were assessed and moved to the home's end of life care unit by a local hospice service. The provider was supplied with enough information about a person to be able to decide if it felt the service could support them safely. The deputy manager described an example when the provider declined to accept such a potential resident as managers assessed the service could not support the person appropriately with their behaviours that others may have found challenging.

Staff support: induction, training, skills and experience

● People and relatives told us they thought staff were appropriately skilled and trained. Staff we spoke with appeared knowledgeable about the people they were caring for and how to support them.

● New staff completed an induction and training when they started. Staff told us this they found this helpful and informative and it included shadowing more experienced staff.

● Records indicated staff received periodic supervision sessions with one of the managers or a nurse. The manager conducted staff performance appraisals annually. Almost all the staff we spoke with felt supported by the management team. One person told us they felt managers could be more supportive at times when the work was stressful. Other staff comments included, "Both home manager and deputy manager are very kind and supportive" and "[The deputy manager] encourages a lot, motivates, pushes you forward."

● The registered manager had a service level training plan in place and records indicated permanent and bank staff had completed training the provider had designated as mandatory. For example, dementia awareness and moving and handling training. Staff said they found their training helpful. We saw the provider had audited training compliance regularly over the last year to ensure staff who had not completed it then did so. The registered manager had assessed nursing staff's clinical competence over the last six months. People and relatives told us they thought staff were appropriately skilled and trained. Healthcare professionals told us the managers were proactive in asking for additional and refresher training.

Adapting service, design, decoration to meet people's needs

● The building was suitable to meet people's needs.

● The provider had made a number of improvements and adaptations to the home environment since our last inspection. These included replacing the home's boilers, repairing people's rooms, laying new carpets, and redecorating rooms and communal areas. We saw this redecoration work was ongoing at the time of our visit. For example, wall paper along a corridor was in the process of being replaced. Staff and a healthcare professional told us they thought the building works were a positive development for the service.

● People's bedrooms were personalised with individual decorations to varying degrees. Communal areas, such as the dining room and conservatory, were light, clean and had enough space for people to access using their wheelchairs and for staff to support them. We saw noticeboards were mounted at a low level so they provided information about activities and planned events accessibly to people using wheelchairs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff supported people to maintain their health and access other healthcare services when required.

● People's care plans included direction on supporting people to maintain good oral health. Healthcare professionals told us people received good oral health support. The managers had also assessed carers' competency in providing this support effectively.

● Assorted local health and adult social care professionals visited the service regularly, including dieticians and tissue viability and diabetes nurses. They told us the staff were proactive in addressing people's

healthcare needs and sought input and advice from healthcare agencies promptly.
● People who were at risk of pressure sores were supported appropriately. Their care plans set out how to support people with or to avoid sores. A local tissue viability nurse told us staff followed their advice and plans appropriately. However, on one unit we saw staff had not kept an up to date record on that day of how they had supported a person to turn in their bed to reduce the risk of developing sores, while this was completed for other days. We discussed this with the unit nurse who told us they had seen the person being supported to change positions and acknowledged the recording of this needed to be addressed.
● The tissue viability nurse said staff pre-emptively supported people to take pain-relieving medicines before wound dressings were changed and were confident in asking other professionals to wait for this. Most staff had attended pressure sore training. The home had been recognised by the local community health team recently for helping people to avoid developing pressure sores after they moved in for over two years.
● Staff worked with other agencies to provide people with joined up care. We saw records of other professionals involved in people's care and staff following their guidance or instruction. All the professionals we spoke with told us the staff were good at sharing information with them about people's health and well-being. Their comments included, "Staff here are happy to receive support" and "Receptive to advice."

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had worked with the local authority when it considered people lacked the capacity to agree to their care arrangements and these may have amounted to a deprivation of their liberty. We saw the provider obtained a copy of the legal authorisation when a person's deprivation of liberty had been authorised.
● Staff had received training regarding the MCA and could explain how they sought consent from people and helped people to make day to day decisions about their care. For example, staff described speaking with people and offering them choices, using pictures to help people with this and understanding how people indicated what they wanted through their body language.
● The registered manager was aware of the legal changes to deprivation of liberty arrangements due to be implemented later in the year we visited.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated by staff in a caring manner. People and their relatives spoke positively about the way staff treated them. One person told us, "I feel it's very homely here." A relative told us, "I really do rate the staff, they're approachable, [they're] never in a rush with me."
- Healthcare professionals told us they had observed staff being polite to people and welcoming to their visitors. Their comments included, "I feel they generally really care" and "They're very understanding."
- Staff spoke about people in a caring way. One member of the care staff told us they thought the staff were, "Very loving." Staff we spoke with appeared knowledgeable about the people they cared for.
- Staff had received training in promoting equality and diversity in their work. People's care plans recorded information about people's religious and cultural beliefs or background. We saw representatives from local churches attended fortnightly to provide a visiting religious service for people. The registered manager told us the service did not currently support anyone who identified as LGBT+. 'LGBT' describes the lesbian, gay, bisexual, and transgender community. The '+' stands for other marginalised and minority sexuality or gender identities. People's care plans recorded information about their personal characteristics, including marital status and cultural and religious background.
- The provider had conducted an 'equality and diversity audit' in the year before our visit. This concluded that the service was promoting people's protected characteristics fairly. A spare office room was available to people as a prayer area while the provider intended to develop a more specific space for this.

Respecting and promoting people's privacy, dignity and independence

- Staff promoted people's privacy and dignity. We observed staff supporting with people with a friendly and respectful approach and responding to people who appeared in discomfort or distress promptly.
- Staff had completed training on promoting dignity and respect for people in their work. Staff described how they encouraged people's privacy and dignity when providing personal care. For example, knocking on people's doors and waiting for a reply, making sure doors and curtains were closed, and speaking with people while supporting them. We also saw and heard staff doing this during our visit.
- The registered manager had conducted regular 'dignity audits' throughout the year prior to our inspection to monitor how staff treated people. These audits noted the registered manager planned to introduce a staff 'dignity champion' promote treating people with dignity and respect and support. However, this had not yet been implemented at the time of our visit.
- Staff explained how they promoted people's independence. For example, prompting and encouraging a person to do things for her or himself. Some people we spoke with told us staff helped them to maintain their independence and said, "The staff are very helpful."

Supporting people to express their views and be involved in making decisions about their care

● People were involved in planning and reviewing their care. People told us staff gave them opportunities to make decisions about their care. People's relatives, where appropriate, were involved as well. This gave people and those important to them the opportunity to make decisions about their care and support arrangements.

● We observed staff supporting people to make day-to-day choices about their care. For example, we saw staff respecting and supporting people if they wanted to move rooms or go outside.

● Staff recognised the role of advocates in supporting people who needed help regarding decisions about their care. Staff worked with people's advocate and provided them with information to help with this.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

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

● People received care in a planned way that recognised and reflected their individual needs and personal preferences. People and relatives said they felt their care was good. One relative told us, "Couldn't rate it higher." Healthcare professionals also said they thought people received care that met their needs appropriately. One commented, "[The staff] tend to know their patients well."

● People's care plans provided information about meeting their needs and reflected a personalised approach to supporting them. For example, one person's plan described how to support a person living with dementia when they seemed confused or upset. Plans reflected people's preferences and wishes, such as their preferred name. We saw most plans stated the foods people did or didn't like, items a person liked to hold, or when a person did not like their feet being touched. However, this was not always clearly recorded for all people.

● The provider had started to implement a new digital care planning system across the service since our last inspection. Nurses and senior staff had access to this system and explained how they facilitated access for care staff. Care staff told us they could access people's care plans and these provided enough information for them to be able to support people. The deputy manager had used the care planning information to recently introduce a one page profile for people. This provided staff with an 'at a glance' overview of people's care needs.

● We also saw staff regularly acting responsively to people's needs when required. For instance, during a mealtime or while being supported to take part in an activity and a person needed additional help with something. A healthcare professional told us, "When people need help or an intervention, [the staff] always go and help straightaway."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's care plans set out information about their communication and sensory needs and how staff should meet those needs. This included if a person was living with a hearing impairment and wore aids for this. Another example was one person's care plan described how they used eye movements to communicate. Another person's care plan noted they could not operate their call bell without assistance, so staff were required to visit and check on them regularly throughout the day. Staff told us how they helped some people to communicate when a person did not use words. For example, by using pictures. We also saw the deputy manager accessing a camera to take pictures of foods to help a person make their meal

choices.
● There were a number of staff working across the home's units who could speak the language of some people and their relatives when English was not their first language.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to engage in a range of social activities. This encouraged people to interact with others to protect them from the risk of social isolation.
● Two activities coordinators arranged a weekly timetable of sessions for people, with several taking place each day. These included games, bingo, bird-feeding, reminiscence, puzzles, exercises, drawing and colouring, and singing. Coordinators had also arranged for an entertainer to visit in the week after our inspection. We observed staff supporting a group of people to play a board game in the conservatory, which people appeared to engage in and enjoy. The timetable was posted the main corridor and in people's rooms. A coordinator told us they offered the activities to people in their rooms and encouraged them to come out, which people also confirmed to us. One person said, "The staff are very encouraging and try and get me to go." A member of staff commented, "They play bingo, scrabble and sing-along. It's very good. I feel the residents enjoy their activities."
● Local church representatives visited every month with children to talk and spend time with people. One person told us they particularly enjoyed those sessions.
● People told us staff always welcomed their visitors, such as friends and family. People could visit at any time, although the provider preferred this was not at lunchtimes so staff had time to support people with their meals.

Improving care quality in response to complaints or concerns
● The provider had appropriate procedures in place for responding to complaints.
● People told us they knew how to make a complaint or raise a concern, although they said they had not felt the need to do so. There was information about this on display in the home. Staff we spoke with also knew how to respond to a complaint and pass this on to a senior member of staff.
● The registered manager kept a record of complaints and actions taken in response to these. The manager conducted a periodic analysis of complaints information to see if any trends could be identified to inform service improvements. Learning from this was passed on to staff at team meetings.

Is the service providing end of life care?
● Staff supported people at the end of their life to experience a comfortable and dignified death. Staff worked with other professionals to enable this.
● The service worked in partnership with a local hospice that specifically commissioned end of life care for up to ten people in the home. Staff also provided end of life care to other people living at the home as well. Palliative care specialists visited on a weekly basis and told us the staff worked in partnership with them to provide end of life care that met people's needs and preferences. One specialist told us, "They do palliative care well."
● People's preferences for their end of life care were set out in their care plans. This included recording when decisions had been made regarding how to support people who were very ill when their health quickly deteriorated. These documented decisions were signed by appropriate clinicians. Healthcare professionals said the staff were committed to ensuring people passed away in a place of their choosing and whenever possible not admitted to hospital. Professionals also told us staff were proactive in contacting them for specialist advice and support regarding people's changing needs at this time of their life.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant while the service management and leadership was consistent, some systems did not always ensure to people received high-quality, person-centred care.

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

- The provider had not always kept up to date some records regarding the management of the service.
- In one unit we found for over half of the 36 days preceding our visit there had been no record of how staff on shift had been allocated to support people. We observed staff between shifts giving and receiving a handover of relevant information about the service, but the conduct and content of handovers was not recorded. Some people's daily fluid intake and turning charts were not fully completed.
- We found no evidence this had impacted on the care people had received, but we raised this issue with the registered manager so they could address it.

We recommend the provider considers good practice guidance on effective care recording and takes action to update practice accordingly.

- The provider used a range of systems to check on and maintain the quality of the service. However, these had not always been effective as they had not identified and addressed the issues we found regarding maintaining records appropriately.
- The provider's quality assurance systems did include monthly or periodic audits of staff files, health and safety checks, bed rails checks, medicines support, kitchen management, and care plans. The registered manager took improvement actions in response to these audits' findings.
- The registered manager and deputy manager were qualified nurses and maintained their registrations with the Nursing and Midwifery Council. The registered manager said they kept their knowledge and competencies up to date by working with the provider's quality assurance manager, attending training and sourcing relevant practice guidance, such as from the National Institute for Health and Social Care. They attended provider forums arranged by the local authority to gather and share good practice information. The registered manager said they felt supported by the directors and other managers in the organisation.
- The provider informed the CQC of important events as required by the regulations. The provider displayed the previous inspection rating on their website and at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People, relatives and health and adult social care professionals spoke positively about the service. A relative told us, "When I am here I see good care, my [family member] would complain if there was anything wrong." A healthcare professional told us they felt people experienced effective care. Their comments

included, "It feels like a working together safe place" and "I would be happy for my relative to live and be cared for there." A representative from the local commissioning authority had visited the service in the week before our inspection and found people were being supporting appropriately.

● Staff and managers spoke about being motivated to provide a good service to people. Staff comments included, "I love the residents - I love to speak to them, support them emotionally" and "We work well as a team." Staff spoke well of the registered manager and deputy manager and said they were supportive of the team. One worker said, "[The registered manager] is very good, always hands on. [They] listen to us." Healthcare professionals also rated the managers positively.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● There were processes in place to respond to concerns about people's care when things may have gone wrong. The registered manager was aware of the provider's duty of candour responsibilities and had taken action when something did not go right. We saw evidence that significant events were investigated in partnership with other agencies.

● The nominated individual and registered manager described an organisational focus on continuing to develop and build on improvements to the service. These included introducing the digital care planning systems, creating a second activities coordinator post so people could be supported with more appropriate activities, reviewing staff employment conditions, and building renovations. One member of staff told us, "There have been a lot of changes… but all for the better. Future improvements included implementing staff 'champions' or leads in falls prevention, infection control and dignity in care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their relatives had opportunities to provide feedback about the service.

● There were regular meetings when staff and managers asked people for their opinions about different aspects of the service, such as the food, proposed new menus, redecorating and activities. Records showed the registered manager also met with people individually when they could not attend these group meetings. We saw action plans were created and carried out based on people's feedback.

● The registered manager held regular team meetings with the nursing and care staff, including with night staff, to discuss the running of the service. Records showed these were used to consider issues such as residents' well-being, mealtimes support, completing care records, and attending training. The registered manager similarly met with the kitchen and housekeeping staff to discuss meals provision. Improvement actions were taken as a result of these meetings.

● The registered manager also held weekly a meeting with the service's leads for people's care and support, catering, maintenance and activities to discuss any concerns, issues, actions required and share information so they could provide consistent care to people.

● The service worked closely with health and social care professionals, particularly palliative care specialists, to provide people with joined-up care. Professionals visited the home regularly and said they had good working relationships with the staff and managers. Healthcare professional told us, "[Staff are] particularly helpful with maintaining a good working relationship with the GP" and "Staff here really communicate well."