Gracewell Healthcare Limited

Gracewell of Bookham

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 28 August 2018 and was unannounced. This was the provider's first inspection since their registration in July 2017. Gracewell of Bookham 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. Gracewell of Bookham is a care home set over three floors that provides nursing and personal care and support for up to 70 older people. At the time of our inspection, 58 people were using the service.

There was a manager in place who had applied to become the registered manager with the CQC. 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. On the day of the inspection the manager was on leave, however the deputy manager was available and spoke with us.

At this inspection, we observed that medicines were not always managed safely. Infection control checks were carried out but were not robust. There were system's in place for monitoring and investigating accidents and incidents, however, learning from these were not disseminated to staff. Food and fluid charts were not always completed in full. The provider did not have an accessible information (AIS) policy in place so that people were provided with information about the service in a format that they could easily understand. Staff understood the Mental Capacity Act (2005), however, best interest meetings had not always been documented. Care plans were not always available in people's care files for staff to consult should the need arise. People were supported to have a balanced diet; however, food and fluid charts were not completed in full and monitored. Care plans did not always record people's diverse needs. There were not effective systems in place to monitor the quality and safety of the home as the provider had failed to identify the issues we found at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe and there were appropriate safeguarding procedures in place to protect people from the risk of abuse. There were enough staff deployed to meet people's needs and the provider followed safe recruitment practices.

Staff received an induction when they started work and were supported through a programme of regular training and supervisions to enable them to effectively carry out their roles. People's needs were assessed prior to moving into the home to ensure their needs could be met. 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 supported this practice. Staff told us they asked for people's consent before offering support. People's care files included assessments relating to their dietary support needs and they were supported to have enough to eat and drink. People had access to healthcare professionals when required to maintain good health and the service worked with them to ensure people received the support

they needed. The service met people's needs by suitable adaptation and design of the premises, which included appropriate signage to help people orientate themselves and appropriately adapted bathrooms to manage people's needs effectively.

People told us staff were caring and respected their privacy and dignity and that they had been consulted about their daily care and support needs. People were supported to be independent wherever possible. People were provided with information about the service when they joined in the form of a 'service user guide' so they were aware of the services and facilities on offer.

People's care plans were reflective of their individual care needs. There were a variety of activities were on offer for people to enjoy and take part in. People were aware of the home's complaints procedures and knew how to raise a complaint. People's religious beliefs were recorded and they were supported to meet their individual needs if required. Where appropriate people had their end of life care wishes recorded in care plans.

Regular staff and residents' meetings were held where feedback was sought from people. Staff were complimentary about the manager and the home. The provider worked in partnership with the local authority and other external agencies to ensure people's needs were planned and met. The manager was knowledgeable about the requirements of a registered manager and their responsibilities about the Health and Social Care Act 2014. Notifications were submitted to the CQC as required. The ethos of the home was to provide high quality, personalised nursing, residential and dementia care.

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.

Medicines were not always managed safely.

Infection control checks were carried out but were not robust.

Risks to people were assessed, identified and managed safely.

There were appropriate adult safeguarding procedures in place to protect people from the risk of abuse.

The home had a system in place to record accidents and incidents and acted on them in a timely manner.

There were enough staff deployed to meet people's needs in a timely manner and the provider followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff understood the principles of the Mental Capacity Act (2005), however best interest decisions had not always been documented.

People were supported to have a balanced diet, but food and fluid charts were not completed in full and monitored.

People's needs were assessed prior to moving into the home to ensure their needs could be met.

Staff completed an induction when they started work and were supported through regular training and supervisions and appraisals.

Staff understood and supported people to make decisions appropriately. Staff told us they asked for people's consent before offering support.

People had access to healthcare professionals when required to

maintain good health.

The service met people's needs by suitable adaptation and design of the premises.

Is the service caring?

Good

The service was caring.

People were involved in making decisions about their daily care and support requirements.

People told us staff were caring and respected their privacy, dignity and independence.

People were provided with information about the service when they joined in the form of a 'service user guide' so they were aware of the services and facilities on offer.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always have access to information that met their communication needs effectively such as in large font or in braille.

Care plans did not always record people's diverse needs.

Care plans were not always available in people's care files for staff to refer to if the need arose.

People's cultural needs and religious beliefs were recorded and they were supported to meet their individual needs.

There was a variety of activities available for people to participate in.

People were aware of the home's complaints procedures and knew how to raise a complaint.

Where appropriate people had their end of life care wishes recorded in care plans.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not have effective quality assurance systems in

place to monitor the quality and safety of the service.

There was a manger in place who had applied to be the registered manager.

Regular staff and residents' meetings were held and feedback was sought from people.

Staff were complimentary about the manager and the home.

The provider worked in partnership with the local authority to ensure people's needs were planned and met.

Gracewell of Bookham

Detailed findings

Background to this inspection

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

This inspection took place on 28 August 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing 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.

Before the inspection we looked at the information we held about the service. This included statutory notifications that the provider had sent CQC. A notification is information about important events which the service is required to send us by law. We used 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 asked the local authority commissioning the service for their views and used this information to help inform our inspection planning.

We spoke with seven people using the service, five relatives, nine members of staff, the deputy manager, two general managers and the regional head of care and nursing. We reviewed records, including the care records of nine people using the service, recruitment files and training records for six staff members. We also looked at records related to the management of the service such quality audits, accident and incident records, and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. We saw medicine fridge temperatures were not consistently recorded and monitored to ensure they were within a safe range. For example, medicine fridge temperatures were not recorded and monitored daily between the 15th and 20th of August 2018 to ensure that medicines were stored at the correct temperatures and they remained effective. We saw that the medicines room on the first floor had not been cleaned and was untidy with boxes, full to the top with medicines that had not been returned to the pharmacy. There were no cleaning schedules in place for the medicines room and the medicines fridge. The last external pharmacy audit in March 2018 recommended that the medicine fridge should be cleaned regularly and a schedule should be put into place. There were no records to show that this recommendation had been implemented.

One person was administered medicines covertly, this is when medicines are hidden in food or drink without the knowledge of the resident. We saw that although there was a procedure for covert medicines in place, this had not been followed. We saw the covert medicine protocol attached to the person's medicine administration record (MAR) showed several gaps. It was not signed by the GP and pharmacist. The was no evidence on record to indicate whether this method of administration had been discussed with the pharmacist to determine its appropriateness. The method of covertly administering the medicine was not recorded on the form. There was no written documentation to show that a best interest meeting had taken place with relevant health professionals and relatives to agree this method of medicines administration. A staff member we spoke to said, "We had a best interest meeting for this person, but I cannot remember who was involved." The staff member confirmed that original documentation for the best interest meeting had been given to the person's family and no copy had been retained by the provider. The staff member said that they had asked the person's family to bring the original best interest documentation a week prior to this inspection, but this had not been followed up. The staff member also confirmed that there had been a recent review of the person's medicines and they were now no longer on covert medicines and were receiving their medicines normally. This had not been clearly documented in the person's care plan.

There was no guidance in place for staff on the support people required with any 'PRN' medicines that had been prescribed to be taken 'as required'. 'PRN' guidance is needed to enable staff to understand when someone may need their 'as required' medicines. The lack of guidance meant that staff (especially agency members of staff) would not have information about the reasons why someone might require a PRN medicine or what the maximum dose was.

These findings were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a medicines administration round and saw that medicines were administered safely by the staff member. We looked at a sample of MAR records and saw they were legible and completed in full without any gaps. There was details available on how each person preferred their medicines to be dispensed and the staff member followed these appropriately. The staff member showed care and patience when administering medicines and they communicated clearly with the person as to what they were doing.

Only staff who had had undertaken medicine training and had been assessed to and competently were allowed to administer medicines.

There was a system in place to manage accidents and incidents and these were investigated in a timely manner. We saw records included details of the accident or incident, what happened and what action was taken. For example, one person suffered a fall, staff assessed the person for injuries and called for a ambulance which took the person to hospital. The person's family was notified and their care plan and risk assessment was updated. However, improvements were needed as no analysis was carried out of accidents and incidents that occurred to look for patterns or trend to reducing the risk from accidents and incidents occurring again and disseminating learning to staff.

A fire risk assessment had been completed on 20 November 2017 and we saw that all actions identified had been recorded as completed on 23 January 2018. Staff we spoke with confirmed they had taken part in fire drills and demonstrated they knew what to do in the event of a fire. Fire safety equipment was checked and serviced regularly. Agency staff we spoke with said they were told what to do in the event of a fire when they started work at the home. However, improvements were needed as we found that fire drill records were not always completed fully to show which staff members took part in them and if there were any issues or learning that needed to be addressed. We found only one record of a night staff fire drill for 2018 and the staff who attended had not signed to confirm their attendance. The provider was unable to verify that all staff had taken part in a fire drill in the last 12 months and this required improvement.

Recommendations in relation to additional fire extinguishers being installed had been made on 2 July 2018 but had not been implemented and there was no record to show why these recommendations had not been followed. Minor issues with the fire safety systems were identified in a report conducted in June 2017 prior to the service opening but we were unable to see that these had been resolved or addressed from the records available. Personal Evacuation Plans (PEEPs) we reviewed did not always quickly identify the level of support people required to exit the building safely and two people's PEEPs had not been reviewed since 8 August 2017.The deputy manager agreed they should be reviewed to check they reflected people's current needs.

The home was clean throughout and there were no malodours noted. However, improvements were needed as records of cleaning carried out were not always recorded and monitored. We examined the cleaning schedule records for one floor and saw that cleaning records had not been completed for 10 days for the month of August 2018. No checks of the cleaning carried out on this floor had been checked and documented. We discussed this with deputy manager who confirmed that there would be regular checks of documented cleaning schedules going forward. We will check this at our next inspection.

People were protected from risk of infection in that there was an infection control policy in place and staff had received training in infection control. We observed staff wearing personal protective clothing (PPE) which included disposable gloves and aprons and washing their hands before supporting people with personal care. Staff spoke confidently about the action they would take minimise the risk of infection. One staff member said, "I always wear gloves and aprons to stop infection."

People told us that they felt safe. One person said, "I feel safe here because there is always someone going around checking on us." Another person said, "I feel quite secure here, all the doors are locked at night."

People were protected from the risk of abuse. There were appropriate safeguarding procedures in place and staff understood the types of abuse that could occur and confidently described who they would contact should they have any concerns. Records confirmed that staff had completed safeguarding training and they

were also aware of the organisation's whistleblowing policy and told us they would not hesitate to use it if required. One staff member said, "I would definitely go to my manager, I know they would take action. The manager followed safeguarding protocols and submitted safeguarding notifications when required to the local authority and CQC.

Risks to people were assessed, identified and managed safely. Risk assessments were carried out in relation to medicines, falls, mobility, nutrition, skin integrity and communication. Risk management plans included detailed guidance for staff on how to manage these risks safely. For example, where one person was at risk of choking and we saw that a speech and language therapist (SALT) had been involved and provided clear guidance for staff on how to minimise this risk. This included ensuring the person was observed whilst eating and drinking and to report any changes regarding the person's ability to swallow. Risks were reviewed regularly and risk management plans were updated to ensure they remained relevant to people's current needs and conditions.

There were enough staff deployed to meet people's needs in a timely manner. One person told us, "I feel there is enough staff." A relative said, "The staff are wonderful and very efficient." The deputy manager said that staffing levels were determined using a dependency tool based on the level of support people required. Staff rotas were planned in advance so staff knew what shifts they were working. Rotas we looked at showed that there were sufficient numbers of staff on duty to meet people's needs. The deputy manager said that the home did use agency staff on a regular basis, but for consistency only selected agencies were used and the same agency staff covered shifts when needed.

The provider followed safe recruitment practices to ensure that only suitable staff could work with people. The provider carried out the necessary recruitment checks before staff started work. Staff files we reviewed included completed application forms, details of employment history and qualifications. References had been sought and proof of identity had been reviewed and criminal record checks had been undertaken for each staff member. Checks were also carried out to ensure staff members were entitled to work in the UK.

Requires Improvement

Is the service effective?

Our findings

We found that people's food and fluid charts were not completed in full by staff as charts did not record information in detail. For example, there were no details in terms of what and how much people were eating for breakfast, lunch and dinner and there were also no records of what snacks people were eating between meals to ensure people were not at risk of malnutrition. There were also no detailed records of how much people were required to drink on a daily basis, what they were drinking and exactly how much they were drinking to ensure they were not at risk of dehydration. We did not see that people were losing weight or were dehydrated, however, improvements were needed. This was to ensure that staff were monitoring people's intake accurately and that if people were identified as being at risk of malnutrition and/or dehydration they were referred to appropriate healthcare professionals in a timely manner.

We brought this to the attention of the deputy manager and the general manager who during our inspection carried out refresher training for all staff on how to accurately complete food and fluid charts. We were not able to assess the impact of the refresher training during our inspection. We will check this at our next inspection of the service.

We observed some areas of good practice in relation to nutrition and hydration. People's dietary needs were assessed and care plans included guidance for staff on how to support them. For example, if people required a high fat, low salt, low sugar diet and their likes and dislikes. People's allergies were also recorded. The chef had a list of people's dietary requirements to ensure they were meeting people's needs. Staff we spoke to were also knowledgeable about people's dietary needs. There was a five-week rotational menu and choices were provided at each meal and people were involved in choosing what they wanted to eat or drink. Menus were available on notice boards throughout the home and outside the dining area on each floor of the home.

Lunch-time observations showed positive interactions between staff and people. Most people were supported to sit at the dining table to eat. People who required assistance to communicate were physically shown the choice of meals and drinks on offer so that they could decide what they wanted to eat and drink. There were sufficient numbers of staff to support people appropriately and we observed people were encouraged to eat independently and assistance offered was appropriate. The atmosphere was calm and kitchen staff supported care staff to serve meals. Staff ensured they were at the right height to talk with and support people. People were observed to be enjoying their meals and we heard them comment favourably about the food. We observed one person asking for a sandwich as they did not want any of the meals on offer, staff immediately informed the person of the variety of sandwich fillings that were on offer and they were provided with a meal of their choice. One person told us, "The food is very good, you can have omelettes or salad if you don't like what the main dish is, it's lovely." A relative said, "[My relative] loves the food, staff have increased [my relative's] portion sizes as they enjoy the food so much." We saw that there was a bistro area available for use by people and their visitors. There were plates of prepared fruit and wrapped biscuits available as well as hot and cold drinks on offer for people to help themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements of DoLS and had submitted applications as required. We saw that where DoLS applications had been authorised that the provider was complying with the conditions applied under the authorisation. Capacity assessments were completed and best interests' decisions made where people lacked capacity to make specific decisions. For example, when people required bedrails. We observed staff seeking people's consent before supporting them with their needs. However, improvements were needed as best interest meetings had not always been documented.

We brought this to the deputy manager's attention, who told us that they would ensure that best interest meetings were carried out and recorded for all people who required this. We will check this at our next inspection.

We observed staff explaining to people how they were going to assist them and asking for their consent before supporting them with their needs. For example, one person required support to eat, we saw a staff member asking the person if they would like support, before assisting them. One staff member said, "I explain to people what I am going to do and ask them if they require my help. If they say no, I respect this."

People and their relatives told us that staff were competent and knew their jobs well. One person said, "All the staff seem to know what they are doing." A relative said, "The staff have a very good understanding of [my relative] condition and new staff get supervision."

Staff were supported to carry out their roles effectively. Staff completed an induction when they joined the home. The registered manager told us staff new to care were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. Records showed that staff completed a programme of training which included safeguarding, infection control, manual handing, health and safety, mental capacity act, dementia, diversity, distressed behaviour and first aid. We saw that refresher training courses were booked for staff in advance to ensure their training remained up to date. One staff member said, "My training is up to date, I enjoy the training." Another staff member said, "It's important to have continuous training to make sure I have up to date knowledge. I have done all my training."

Records showed that staff were supported through regular supervisions. Areas discussed within supervisions included training, performance, infection control and policies. One staff member said, "I do have supervisions. They are good as I can discuss any issues and concerns and also get feedback." Another staff member said, "I have regular supervisions. My manager gives me help and guidance and I have the chance to speak openly to them."

Assessments of people's needs were carried out prior to them moving into the home. The deputy manager told us that prior to any person being accepted by the service an assessment of their needs was undertaken to ensure the service would be able to meet their needs. These assessments, along with referral information from the local authority were used in producing individual care plans and risk assessments. This was to ensure that staff had the appropriate guidance to meet people's individual needs effectively. For example, the home used recognised tools such as Malnutrition Universal Screening Tool (MUST) to assess nutritional

risk.

People had access to healthcare professionals when required to ensure their day to day health and well-being needs were being met. The provider worked with other organisations to deliver effective care to people, these included a regular GP to visit the home on a weekly basis, district nurses, audiologists, opticians, chiropodists and dieticians. One person said, "The GP visits the home every week and the optician visits." Another person said, "A chiropodist comes once a month."

The home met people's needs by suitable adaptation and design of the premises, which included appropriately adapted bathrooms to manage people's needs effectively and appropriate signage to help people orientate themselves and promote people's independence. People's bedrooms were decorated with their own personal effects such as furniture, photos and pictures. We also noted that people's names were displayed outside their bedroom doors together with memory boxes. This enabled people to easily identify their own bedrooms.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind, patient and caring. One person told us, "Staff are very nice and friendly. If you want the staff they are always there for you, they are so kind." Another person said, "Staff know what I like and what I need." A relative said, "Staff are very kind to [my relative] and treat them very well, they always give them lots of time."

We observed staff treated people with dignity and in a respectful manner. People were well dressed and looked comfortable. People responded positively when staff approached them. The atmosphere throughout the home was calm and friendly and we saw staff took their time and gave people encouragement whilst supporting them. Staff addressed people by their preferred names and showed compassion and understanding. For example, when one person was anxious, a staff member used distraction techniques by reassuring them, talking to them calmly and offering them a drink.

Staff were knowledgeable about people's individual likes, dislikes and preferences such as their hobbies and the foods they liked. For example, one staff member said, "One person really enjoys walking in the garden when the weather is good." People were involved in decisions about their daily care such as what time they wanted to wake up or go to bed and what they wanted to wear. People's individual needs were identified and respected. One person told us, "Staff always ask me if I would like help with my walking." Another person said, "I always tell staff what I want to wear, I do like to dress nicely."

We saw that staff protected people's privacy and dignity. We saw staff knocked on people's doors and obtained permission before entering rooms. Staff told us they closed curtains and ensured doors were closed before supporting people. Staff explained to people what they would be doing before supporting them. One staff member said, "I knock on people's door before entering. I always shut curtains and doors." People's information was kept confidential by being stored in locked cabinets in the office and electronically stored on the provider's computer system. Only authorised staff had access to people's care files and electronic records. Staff told us and we saw that they promoted people's independence by encouraging them to carry out aspects of their personal care such as washing their face, eating and drinking and choosing their clothes for the day. One staff member said, "I do encourage people to do what they can, such as trying to maintain their mobility or combing their hair."

Relatives and friends were encouraged to visit people at the home in order to maintain relationships that were important to them. Staff said that relatives and friends were welcome at any time and there were no restrictions on visits to the home. One relative said, "I come regularly to visit [my relative] and I always feel welcome." People were provided with information about the service when they joined in the form of a 'service user guide,' which included the complaints procedure. This guide outlined the standard of care to expect and the services and facilities provided at the home.

Requires Improvement

Is the service responsive?

Our findings

From April 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. The provider did not have an accessible information policy in place which affirmed their commitment to ensure people were provided with information about the service in a format which met their needs and this required improvement. This included for example, providing information to people in a format they could understand if they were unable to communicate or in braille. However, we did see that there was some signage for bathrooms in braille for people who were living with sight problems.

We brought this to the deputy manager's attention and were told that the provider would put an AIS policy in place and ensure that information was available in formats that people could easily read or understand, so that they can communicate effectively. They also said that if required they would be able to provide people with information in larger print. We will check this at our next inspection.

Improvements were needed as care plans were not always available in people's care files for staff to consult should the need arise. Staff were required to look at electronic care plans for people, however, if the computer was being used by another staff member, especially agency staff members as they did not have quick access to people's care plans if required as they were not always available in people care files. Care plans documented people's spiritual needs and although there was no-one at the home who required support regarding their cultural and diverse needs there were no systems in place to establish how they could be supported in order to meet any of these needs. This required improvement. We brought this to the deputy manager's attention who confirmed that they would ensure that all diverse needs would be assessed going forward and plans put in place on how to support people should they require this. We were told that a spiritual representative visited the home on a monthly basis so people who chose to, were able to practice their faith.

People's care and support needs were being met and people were involved in planning their care and support needs. One relative said, "We do have discussions about [my relative's] care plan." Another relative said, "[My relative's] needs are met, the staff seem to have a very good understanding of [my relative's] condition."

People's needs were assessed and care plans had been planned and developed based on an assessment of their needs, which had been carried out by the provider together with the local authority where they had commissioned the service. Care plans contained information about people's desired outcomes, such as increasing their mobility. Care plans also included details of the support people required and covered areas such as medicines, nutrition, skin integrity, mobility and communication. This also included the number of staff people needed to support them on a daily basis and the equipment they required, such as walking aids. Care plans included information about people's life histories, choices and preferences as well as information about the things that were important to them. This included things like hobbies and what they liked to wear

during the night.

People were encouraged to participate in a variety of social activities that met their needs. The home employed an activities coordinator, who attended the home five days a week and the coordinator was supported by seven volunteers. We saw that there was an activities weekly planner in place, activities on offer included one to one time, arts and crafts, armchair exercises, garden walks, flower arranging, baking, ballroom dancing and movies. There were also activities to help stimulate people living with dementia such as sensory soft toys, memory games and reminiscence activities. We met with the activities coordinator who told us that people were also invited to music shows from outside entertainers. One person said, "I enjoy the seated chair yoga and other exercises." A relative said, "People sometimes go for activities in the local village hall and recently attended a beer tasting afternoon."

The service had an effective system in place to manage complaints. The service had a complaints policy in place and system to log and investigate complaints. People and their relatives knew how to raise a complaint if they needed to. Complaints were investigated in line with service's complaints policy and in a timely manner and the complaints file included forms for recording and responding to complaints. One person said, "If I had to make a complaint I would go to the manager, but I haven't had to." Another person said, "I do know how to make a complaint but have not had to."

People had advanced care plans if required to document their end of life care wishes. This ensured people's care plans recorded what was important to people and if necessary would consult with relevant individuals and family members to ensure people's preferences and choices for their end of life care were acted upon. The home provided appropriate end of life care to people with the support of the local hospice, who were available for staff as an information resource if needed. One relative said, "We have not looked back since and we have peace of mind that [our relative] is having the care that they so deserve. We cannot thank the staff enough, they give excellent care. They have also involved the hospice."

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality and safety of the home, however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection and as detailed in the report. For example, the last internal medicine audit carried out in May 2018 did not identify that a fridge cleaning schedule had not been implemented following the recommendation in the external pharmacy audit in March 2018. The internal medicines audit did not identify that the covert medicine (medicines given to a person without their consent) protocols procedure had not always been followed and implemented. It also did not identify that that there were no individual 'PRN' (as and when) medicine protocols in place and there was no guidance in place for staff on the support people required with any 'PRN' medicines. Care plans had not been audited therefore did not identify that covert and PRN medicine protocols were not in place and that food and fluid charts for people had not been completed in detail to monitor people's intake accurately and ensure that people at risk could be identified and referred to appropriate healthcare professionals in a timely manner.

The provider did not have an accessible information (AIS) policy in place so that people were provided with information about the service in a format that they could easily understand due to disability, impairment or sensory loss so that they could communicate effectively. Audits of the premises were not always robust. The maintenance person told us they did a daily walk around and the manager also carried out a daily walk around. However, no records documenting these walk arounds were provided to verify what was looked at and checked and if issues were identified and acted on. We asked for the infection control audits in line with Department of Health guidance and these could not be provided.

These findings were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the deputy manager took action and addressed concerns that we found during this inspection, this included putting medicine protocols in place, ensuring that cleaning schedules for the medicines room and fridge are completed. They also confirmed that audits of premises would be robust, this included ensuring daily walk arounds were documented and any issues identified, recorded and appropriate action taken when required. We will check on the progress of these at our next inspection of the service.

The service had a manager in post who had applied to be the registered manager for the home. The manager was knowledgeable about the requirements of a registered manager and their responsibilities about the Health and Social Care Act 2014. Notifications were submitted to the CQC as required. The ethos of the home was to provide people with high quality personalised nursing, residential and dementia care. One staff member told us, "The home really does deliver its ethos on a daily basis". The manager told us that they worked closely with the local authority to meet people's needs. The local authority confirmed this.

People, their relatives' and staff we spoke to were complimentary about the manager. One person said, "I have met the new manager and they are very nice." A relative said, "I have met the new manager and she has

been very helpful." One staff member said, "The manager is open-minded, approachable and kind."

Resident and relatives' meeting were held monthly to obtain feedback from people about the home. We saw meetings were minuted and areas discussed included activities, healthcare professional visits, and meals. We saw that one person said that sometimes there was a duplication of meal on a given day. For example, there would be lasagne for lunch then a different pasta dish for dinner. Records showed that this had been raised with the chef who had made appropriate changes to the menu. This meant that the provider had acted on people's feedback and used it to drive improvements. One person said, "I always go to resident meetings."

Regular head of department and staff meetings were held to discuss the running of the service and ensure staff were aware of the responsibilities of their roles. We attended a daily meeting that was held for heads of department, where they discussed staffing, handovers, hospital admissions, accidents, admissions and nutrition. Following this meeting, minutes of the meeting were circulated to all staff. We also saw the minutes of the last staff meeting for June 2018 showed items discussed included training, staffing, health and safety and timekeeping. One staff member said, "I enjoy attending staff meetings and getting together as a team."

The deputy manager told us that surveys to gain people's and their relative's feedback about the home were due to be carried out later in the year. The feedback received would be used to drive improvements. The deputy manager told us they worked in partnership with other agencies, including local authority commissioners, healthcare professionals and the local hospice who were involved in supporting people. We contacted staff from a commissioning local authority who confirmed that they were happy about the care and support people received.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality and safety of the home were not always effective.