Nicholas James Care Homes Ltd

Edward House

Inspection report

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Date of inspection visit:
05 November 2018

Date of publication:
13 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 5 November 2018. Edward House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Edward House is situated in Burgess Hill in West Sussex and is one of a group of homes owned by the provider, Nicholas James Care Homes Limited. Edward House is registered to accommodate 22 people. At the time of the inspection there were 19 people accommodated in one adapted building, over two floors. Each person had their own room and access to communal bathrooms. The home provided accommodation for older people and those living with dementia.

The home had a registered manager. A registered manager is a '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 home is run. The management team consisted of the registered manager, a deputy manager and senior care assistants. An area manager also regularly visited and supported the management team.

At the previous inspection on 11 April 2016, an area identified as needing to improve was people's access to stimulation and interaction, to occupy their time. At this inspection, it was evident that improvements had been made. An activities coordinator had been recruited and people were provided with activities that they found engaging and enjoyable. People had also enjoyed visits outside of the home. One person told us, "They are very good to me. I went to a World War Two local airfield where they have a museum with pictures of the aircraft that flew from there. I enjoyed that".

Although improvements had been made since the previous inspection on 11 April 2016, at this inspection we identified concerns about the care people received. Medicines were not always administered or managed safely. One person who had a specific healthcare condition, did not always receive their medicines in a timely or person-centred way. Appropriate checks to ensure people received the correct medicines were not always made. One person, who was living with dementia, accessed the community independently. The registered manager had not identified, or taken appropriate action, to mitigate potential risks that might occur. Another person, sometimes displayed behaviours that challenged others. Staff told us that these occurrences were becoming more frequent. An incident had occurred where another person, as well as a member of staff, had been struck by the person. The registered manager had not considered this in accordance with the provider's safeguarding procedures and had not raised the incident with the local authority, so that this could be considered under safeguarding guidance. The failure to identify and mitigate risks, to ensure people were receiving safe care and treatment, was an area of concern.

There was a lack of oversight of staff's practice and of the systems and processes that were in place to ensure people received good care. Audits conducted by the registered manager as well as the provider, had

failed to identify shortfalls that were found at the inspection in relation to medicines management, a potential safeguarding concern, staff competence in relation to dispensing and administering medicines and a lack of understanding about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Neither had they identified that there were insufficient assessments and guidance provided to staff in relation to people's specific healthcare needs. That reviews had sometimes failed to identify any changes in people's needs or support requirements. That staff had failed to accurately document decisions that related to people's care. Care was not always person-centred and people's expressed wishes, about the gender of their care giver, was not always respected. The lack of oversight to assess, monitor and improve the quality and safety of the services that people experienced was an area of concern.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible. The policies and systems in the home did not always support this practice. This was identified as needing to improve.

People were complimentary about the food and drink. They told us they had choice and staff respected their right to change their mind. One person told us, "If you don't like anything they will make you an omelette, a jacket potato or a sandwich". However, people did not always have access to a dignified or sociable experience.

There were appropriate recruitment procedures. People were cared for by sufficient numbers of staff to meet their needs. One person told us, "I think they have enough staff to keep us safe because if there are any problems they stay on to help out. You cannot fault them".

People were protected from infection and staff demonstrated correct techniques to ensure that cross-contamination was minimised.

People were supported to access healthcare facilities to maintain their health. They told us that they were supported to access GPs as well as external healthcare professionals.

People were happy living at the home. They told us that staff were kind, caring and compassionate.

People were involved in their care and able to contribute to discussions. People were supported to plan for their end of life care.

People were aware of how to raise concerns and complaints. Residents' and relatives' meetings, as well as surveys, enabled people to voice their opinions and make suggestions about the way the home was run.

People had space to be with others or to spend time on their own. People were complimentary about the environment and told us that it was 'homely' and met their needs.

People and staff were complimentary about the management of the home. People told us that they could approach the management if they had queries about their care.

This is the first time that the home has been rated as requires improvement. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

Medicines were not managed safely. People did not always receive their medicines when they needed them.

Not all risks to people's safety had been considered, identified or mitigated. Measures were not always in place to minimise risks to people's safety.

There were sufficient staff to ensure people's needs were met.

People were protected from the spread of infection.

Is the service effective?

Requires Improvement

The home was not consistently effective.

The provider had not always assessed people's capacity when making specific decisions. Some people were deprived of their liberty unlawfully.

Staff did not always have the necessary skills and competence to meet people's needs.

People had enough to eat and drink and were complimentary about the food. People were not always provided with a dining experience that enabled them to have a sociable and dignified experience.

People had access to healthcare services and their healthcare needs were met.

Is the service caring?

Requires Improvement

The home was not consistently caring.

People's privacy was not always respected or maintained.

People told us staff were kind and continued to support them to be independent.

People were involved in their care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People were not always supported in a person-centred way.

People were supported to engage in activities, interaction and stimulation.

People and their relatives were made aware of their right to complain.

People could plan for their end of life care.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes had not identified the shortfalls that were found at the inspection. There was a failure to continually improve the service.

Feedback about the leadership and management of the home was positive.

People were involved in decisions that affected the running of the home.

Edward House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 5 November 2018. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience had experience of older people's services.

Before this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had sent us. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return (PIR). A PIR 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.

Before the inspection we contacted the local authority and a local Healthwatch group, who had recently visited the home, for their feedback. During our inspection we spoke with people, three members of staff, the deputy manager, the registered manager and the area manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for four people, three staff records, quality assurance audits, incident reports and records relating to the management of the home. 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 observed the care and support people received as well as the lunchtime experience and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. Comments from people included, "I feel safe because they have fire drills every week" and "They give me my medication". Despite people's positive comments, we found areas of practice that required improvement.

Medicines were not always managed safely. People were supported to take their medicines by trained staff. Staff were respectful when administering medicines and involved people in the process, explaining their actions and respecting people's wishes when they refused medicines. There were clear guidelines for staff to follow, as well as information that could be passed to other healthcare professionals if a person had to transfer to another setting. However, staff did not always follow guidance and people did not always have access to their medicines when they needed them.

Staff had completed medication training, however, there were concerns about their understanding and competence. Staff demonstrated a varied understanding of administering medicines safety. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care staff should follow the six R's when administering medicines. These include, right resident, right medicine, right route, right dose, right time and a resident's right to refuse. We observed medicines being administered in an unsafe way. Appropriate checks to ensure that the correct prescribed medicines were dispensed were not followed. This included not checking the information on the medicine labels prior to dispensing as well as dispensing more than one person's medicines at once. These practices created potential risks that people may have been given incorrect medicines. When people were prescribed medicines on an 'as and when required' basis, staff did not always ask people if they required their medicines and instead signed to say that the person did not need them. This meant that there was the potential that people did not have access to their medicines when they required them. Medicine administration records (MAR) were sometimes signed to state that people had taken their medicines, before staff had observed people taking them.

One person was living with Parkinson's disease. Medicines had been prescribed to help manage their condition and associated symptoms. Parkinson's UK recognise the importance of medicine optimisation for people living with Parkinson's disease. It states that getting Parkinson's medication on time is essential for symptom management. Guidance for the person's medicines advised, 'Take them at regular time intervals according to your doctor's instructions' and 'Do not change the times at which you take your tablets for Parkinson's disease'. Records showed that the person had consistently not had their Parkinson's medicines as they had not been awake during the prescribed administration times. This had been identified within an external audit conducted by a pharmacist, who upon identifying the issue, had arranged for the person's GP to review the prescribing times to better align with the person's needs. However, it was not evident what action the registered manager had taken prior to this to ensure that the person's medicines were reviewed to help them manage their health condition.

Following the review of the person's Parkinson's medicines by their GP, the administration times had been changed. This helped to ensure that they were given at times when the person was more alert and able to

take their medicines. The MAR showed the prescribed administration times, however these differed from the times the person had taken their medicines. Staff told us that the person would regularly stay in bed until mid-afternoon and would then be supported to have their medicines once they were aware. They explained that the person would then be supported to have their next scheduled medicines at the usual time. This meant that the person was not supported to have their medicines according to the prescribing guidelines. There was also a risk that there was insufficient time in-between doses of medicines. There was a risk that because the person did not receive their Parkinson's medicines according to the prescribing guidelines, that the symptoms of their condition were not well-managed.

It was not evident that all risks to people's safety were considered or mitigated. One person, who was living with dementia, accessed the local community independently. Although the person was supported to remain independent, there was no documented risk assessment made available at inspection to demonstrate that risks to their safety had been identified or managed. When this was raised with the registered manager they were unable to provide any assurance that risk had been considered and mitigated to ensure the person's safety. After the inspection they informed us that there had been a documented risk assessment which had been stored elsewhere. However, they were unable to provide this on the day of inspection to demonstrate that risks had been considered and mitigated.

The provider had not done all that was reasonably practicable to assess or mitigate the risks to the health and safety of people receiving care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that all people were being protected from the risk of abuse. Staff had undertaken training on how to keep people safe from abuse. However, measures to ensure that people were protected from harm from other people who lived at the home, had not always been considered or mitigated. Records documented that one person who was living with dementia, had demonstrated behaviours that challenged others. They had struck another person as well as a member of staff. A referral to the safeguarding team at the local authority had not been considered or made to ensure the person's safety. When the registered manager was asked if this had been considered in line with the provider's safeguarding procedures, they explained that it had not as the people involved in the incident had not sustained any injuries. This is an area of practice in need of improvement.

Appropriate pre-employment checks had been made before staff started work. Their employment history and references were obtained. This helped to ensure that staff were safe to work with the people that they supported. People had access to sufficient staff to meet their needs. When people called for staff's assistance they received this in a timely way. One person told us, "I think that they have enough staff to keep us safe because if there are ever any problems they stay on to keep us safe. You cannot fault them". Consideration of staff's skills and levels of experience were made. New or temporary staff were allocated to work alongside existing staff to ensure that they were supported to have a good awareness of people's needs.

Accidents that had occurred had been recorded, monitored and analysed to identify trends. One person, who did not have a history of falls, had experienced several falls in quick succession. Staff had identified this and had arranged for the person to have tests with their GP. Lessons were learned and information from the analysis of accidents was used to inform staff's practice and supporting documentation. For example, risk assessments and care plans were updated to reflect the change in people's needs following the accident.

People had access to equipment that were safe. Equipment was regularly checked to ensure people's safety. Infection control was maintained and the home was clean. Staff used personal protective equipment, such

as disposable aprons and gloves, when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination.

Requires Improvement

Is the service effective?

Our findings

People told us that staff respected their right to be involved in decisions that affected their care. People's consent was gained when staff supported them with day-to-day decisions. Despite this, we found an area of practice that required improvement.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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.

Six people had a DoLS authorisation, five of whom had conditions associated to their DoLS. Records showed that staff had not always worked in accordance with these. For example, one person's DoLS condition advised staff to ensure, whenever possible, that the person had access to female care staff when they were being supported with their personal care needs. It also advised that the person be supported to practise their faith by having regular visits from members of the local church. Records showed that the person had consistently been supported by male members of staff, despite their previously expressed wish of preferring female care staff. They had also not had visits from a local church to enable them to continue to practise their faith. When staff were asked why the person's previously expressed wishes or the conditions of their DoLS had not been met, they explained that the person's relative had stated that these no longer needed to be honoured. Staff explained that the person's relative had a Lasting Power of Attorney (LPA) and therefore had the legal right to be the sole decision-maker on behalf of the person. However, records showed that this was not the case. The person's relative had an Enduring Power of Attorney (EPA) which only enabled them to be the sole decision-maker on matters affecting the person's finances. Staff did not have a good understanding of the differences between LPAs and EPAs, they had not ensured that the person's wishes were respected or that the conditions of their DoLS were being adhered to.

One person's DoLS authorisation had expired 13 days prior to the inspection. The registered manager had not identified this and had not made another DoLS application to the local authority. When this was raised with the registered manager they explained that this was an oversight and immediately made an application.

Some people, had a health condition that had the potential to affect their decision-making abilities. They required constant support and supervision from staff. Staff told us that these people were unable to leave the home without staff support to ensure that their safety was maintained. The registered manager had not

considered people's capacity to consent to this. They had not made DoLS applications to ensure that people were not being deprived of their liberty unlawfully.

The provider had not ensured that people were not deprived of their liberty for the purpose of receiving care and treatment without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not always worked in accordance with the MCA to ensure that people's capacity was assessed when making specific decisions. Staff told us that community nurses were visiting the home to administer flu injections to people. When the registered manager was asked how people had consented to these, they explained that people would be asked on the day. However, most people were living with dementia which had the potential to affect their level of understanding. People's capacity to consent to the flu injection had not been formally assessed and the decision to have the flu injection had not been made in the person's best interests or in consultation with others who were involved in the person's care. Staff's understanding about MCA is an area of practice that needs improvement.

People's needs were assessed before they moved into the home and were reviewed on an on-going basis. Some people had specific healthcare conditions such as Epilepsy and Parkinson's disease. Care plans and associated risk assessments had not identified these specific healthcare conditions and staff were not provided with guidance about how to support people in the most appropriate way. Care plans were brief and generic and reviews had not always identified changes in people's needs. For example, one person had consistently experienced weight loss. Reviews of their fluid and dietary intake care plan had not recognised or documented the weight loss and records did not evidence the action that had been taken in response. The assessment of people's needs as well as the review of people's care to ensure that their care continued to meet their current needs, are areas of practice that need improvement.

One person told us, "I think the staff are well-trained for the work they have to do". However, staff training and development was not always effective. People told us that staff were competent and had the skills required to meet their needs. Staff had access to an induction and on-going training which the provider felt essential for their roles. Staff told us that they felt valued and supported in their roles. They felt that the management team were friendly and approachable. Regular formal supervision and annual appraisals were provided to enable staff to receive feedback on their practice and enable them to identify any learning and development needs. However, there was a lack of direct supervision of staff's practice to ensure that they were safely and effectively meeting people's needs. Records and observations of staff's practice indicated concerns over the effectiveness of the training staff had undertaken. For example, not all staff were competent to administer medicines. There was a lack of understanding in relation to MCA and DoLS. Staff had not always identified potential risks to people's safety and not all people's needs had been considered or assessed. The understanding of staff as well as the direct supervision of their practice, to ensure that they could safely and effectively meet people's needs, is an area of practice that needs improvement.

People were complimentary about the food and had sufficient quantities to eat and drink. They told us that they had choice and that staff respected their right to change their mind if they disliked their original choice. One person told us, "If you don't like anything they will make you an omelette, jacket potato or a sandwich". Consideration of the atmosphere and dining environment had not always been made. Staff administered medicines whilst people were having their lunchtime meal. Two large medicine trollies were positioned in the middle of the dining room whilst people were eating. Medicines were then dispensed and administered to people whilst they were eating their meals. Several people were asked to take liquid medicines in-between mouthfuls of food. This did not create a relaxed and enjoyable dining experience. Staff were mindful of being available to offer support to people if necessary. However, they stood over people watching

them eat and did not take the opportunity to sit and interact with them to create a sociable and interactive experience. These observations were fed-back to the registered manager who explained that they would review the mealtime experience people received.

Staff recognised when people were not well and worked with external healthcare professionals to ensure people received coordinated care. One person told us, "GPs come in once a week and will see you if you are unwell". People, and their relatives were informed about decisions so that they were aware of how their health was being managed.

People told us that the home felt 'homely' and welcoming. People had access to shared communal areas as well as private rooms if they preferred to spend time alone. People could personalise their bedrooms with furniture and ornaments that were important to them. Adaptations to the decoration of people's bedroom doors was in the process of being completed. Doors had been decorated to resemble a front door, using people's preferred colours. This helped people who were living with dementia to orientate and recognise their rooms.

Requires Improvement

Is the service caring?

Our findings

There was a warm, friendly and welcoming atmosphere. People told us that staff cared for them and that they were kind. However, despite this we found an area of practice that needed improvement.

People were treated with respect and their privacy and dignity was maintained throughout most interactions with staff. Staff were mindful and sensitive to people's needs when supporting them to access bathroom facilities and when assisting them with their personal care. However, some interactions did not always respect people's privacy and dignity. There were three communal toilet facilities for people to use. Two of these did not have locks on the doors to enable people to have privacy when they used the facilities. When staff were asked why people were unable to lock toilet doors, they explained that they were unaware that the doors did not have locks on. The registered manager explained that they would ensure locks were installed so that people could use these to maintain their privacy. Staff were aware of the importance of regularly weighing people to ensure that they did not experience unplanned weight loss. Although, this was good practice, staff did not ensure that people were weighed in a dignified manner that maintained their privacy. A weighing-scales chair was brought into the main communal lounge and staff encouraged people to take turns sitting on the scales whilst in view of other people. This was fed back to the registered manager who acknowledged that that this was not best practice and explained that they would raise this with the staff team to avoid reoccurrence. The promotion of people's dignity and privacy is an area of practice that needs improvement.

All other interactions with people showed that staff were kind, caring and compassionate. Positive interactions were observed and staff took time to sit and interact with people. One person told us, "They are so very kind. They took me to the local library as I still had my ticket".

People and their relatives could express their needs and wishes. They told us that they were asked about and involved in their care. Regular residents' and relatives' meetings were held. These enabled people to be kept informed of what was happening at the home. They were also able to share their views and opinions. Surveys were sent to people and their relatives to gain their feedback so that the provider was aware of their experiences. People could have access to advocacy services if they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People's privacy, with regards to information that was held about them, was maintained. Records were stored in locked cabinets and offices and conversations about people's care were held in private rooms.

People could remain independent. We observed people independently walking around the home with their mobility aids and choosing how to spend their time. One person also accessed the local community independently. One person told us, "I keep my independence by doing things for myself".

People's diversity was respected and people were treated as individuals. Staff adapted their approach to meet people's needs and preferences. People maintained their identity and they wore clothes of their

choice. Information about people's preferences was documented in their care plans. For example, one person's care plan informed staff that the person liked to wear lipstick each day. People told us that staff respected their preferences.

People could maintain relationships with those that were important to them. People had access to telephones so that they could contact family and friends and could receive visitors. Staff supported people to access the local community to enjoy shared conversations and cups of tea with others.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 11 April 2016, an area identified as needing improvement related to people's access to activities to occupy their time. Although some planned, group activities were provided, people spent most of the day unoccupied and unengaged. At this inspection, it was apparent that improvements had been made. A dedicated activities coordinator had been recruited and people had increased access to interaction and stimulation to meet their needs. Despite this, not all of staff's actions were responsive to meet people's specific healthcare needs. This was an area of practice that needed improvement.

There was a lack of person-centred practice when supporting a person who had Parkinson's disease to have access to medicines to manage their health condition. The registered manager had not ensured that they acted in a person-centred way to ensure the person had access to sufficient monitoring and support to enable them to manage their condition. People had been asked about their preferences with regards to the gender of staff. Most people told us that this was respected, however, records for one person, who was living with dementia, showed that despite their previously expressed wishes, their preference for a female member of staff had not always been respected. More information about these examples can be found within the Safe and Effective sections of this inspection report.

Since the previous inspection on 11 April 2016, an activity coordinator had been recruited and had devised an activity programme based on the types of activities people had expressed an interest in pursuing. These included group activities such as arts and crafts, skittles and Bingo. Although most care staff were busy, people told us that they took time to speak to them and engage in conversations. Care staff supported people to enjoy visits outside of the home to local garden centres or shops. One person told us, "They are very good to me. I went to a World War Two local airfield where they have a museum with pictures of the aircraft that flew from there. I enjoyed that".

We observed that people enjoyed taking part in activities. People were observed smiling and laughing and enjoying conversations with one another and staff. When people had differing needs, for example, if they were living with dementia, staff ensured that they too had access to stimulation that they would find engaging. Music was played and people were observed tapping their feet or humming along to it as well as enjoying dances with staff. This created a fun, lively atmosphere. People's right to not participate in these activities was respected. Some people preferred to read newspapers, watch television or relax in their armchairs. Links had been maintained with a local service for adults who had learning disabilities. Weekly meet-ups took place where people enjoyed interacting and learning from each other. Activities surveys had been sent to people to gauge their opinions on the activities that were offered. Activities were also discussed during the regular residents' and relatives' meetings. There had been mixed feedback about people's access to activities and when suggestions had been made staff had listened to these and taken these on board. Changes had been made to the type of activities, in response to people's feedback, to ensure that people were able to take part in opportunities that they enjoyed.

People were provided with a call bell so that they could call for assistance from staff. For people who were unable to use a call bell, due to their capacity and understanding, regular checks were undertaken to ensure

people's safety when they were in their rooms.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff ensured people's communication needs had been identified at the initial assessment and formed part of their care plans. These documented the best way to communicate with people. Information for people and their relatives, if required, could be created in such a way to meet their needs and in accessible formats to help them understand the care available to them.

Posters, informing people of how to make a complaint were displayed. Residents' and relatives' meetings as well as surveys provided opportunities for people and their relatives to share their opinions. People told us and records confirmed, that people could speak freely and air their views. People told us that they were happy with the care they received. People and their relatives told us that they would feel comfortable raising concerns. When people or their relatives had done this, records showed that the provider had taken appropriate and timely action to deal with these.

People were provided with the opportunity to plan for their end of life care. The provider worked in accordance with the Gold Standards Framework. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives. People had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Some people did not want to discuss this and staff had respected their wishes.

Requires Improvement

Is the service well-led?

Our findings

People and staff were complimentary about the leadership and management of the home. However, despite these positive comments, we found an area of practice that required improvement.

The provider's ethos was to provide a person-centred and resident-led, happy and secure environment. They emphasised the importance of their shared values of promoting independence and individuality, maintaining people's dignity and engaging with people's families. It was not always evident that their ethos and values were demonstrated in practice. There were concerns about the registered manager's and provider's oversight and their overall ability to maintain standards and to continually improve the quality of care. Quality assurance processes were not always effective. Areas that were identified as part of this inspection had not been picked-up and acted-upon by either the registered manager's or areas manager's quality assurance audits. For example, the untimely administration of medicines, the identification of risk to assure people's safety and the lack of care plans and reviews to meet people's current needs had not been identified by the management team. Managers had not sufficiently supervised staff to ensure that their practice was appropriate and met people's needs. They had not identified the poor practice that staff demonstrated when dispensing and administering medicines or when supporting people in way that did not promote their privacy and dignity. It had not been identified that there was a lack of understanding and practical implementation of MCA and DoLS. Neither had it been recognised that a safeguarding referral had not been made to the local authority when there were concerns about a person's safety.

Records, to document the care people had been provided with, had not always been completed sufficiently. When queries about people's care were raised with staff and the registered manager, they explained that discussions and agreements had been made with external healthcare professionals. However, these discussions were not documented in people's care records and therefore it was not evident which agreements and decisions had been made in relation to people's care.

The provider had not ensured that they assessed, monitored or improved the quality and safety of the services provided in the carrying on of the regulated activity, including the experience of people in receiving those services. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were complimentary about how the home was managed. They told us that the registered manager was friendly and approachable and that they could go to them if they had any concerns or queries. Regular staff meetings enabled staff to be involved in decisions that affected the running of the home. Staff told us that their suggestions and opinions were welcomed and listened to. Regular formal supervisions and appraisals enabled staff to share their ideas and to receive feedback on their practice and development. Staff told us that they found these supportive and that they felt valued.

People had been invited to be involved in decisions that affected the home. Regular residents' and relatives' meetings ensured that people could air their views and discuss any ideas or suggestions. Records showed that action had been taken in response to people's feedback. For example, following people's suggestions

changes had been made to the menu and activities that were provided. Regular surveys were also sent to gain further feedback.

People told us and records confirmed, that the manager and provider demonstrated their awareness of the duty of candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Records showed that relatives had been kept informed of any changes to people's needs.

The provider had complied with the CQC registration requirements. They had notified us of certain events and incidents to ensure that we had an awareness and oversight of these to ensure that appropriate actions had been taken.

Links with external healthcare professionals and local authorities had been developed to promote a coordinated approach to people's care. There was an emphasis on engaging with the local community to provide shared experiences for people. This helped to ensure people were not isolated and still felt part of a community.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users. Neither had they ensured that there was proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. The registered person had not ensured that service users were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Good governance.

The registered person had not ensured that systems and processes were established and operated effectively to:

Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.