Hazeldene House Ltd

Hazeldene House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 12 September 2018, and 15 and 16 October 2018. The inspection was unannounced.

Hazeldene House is registered as a domiciliary care service and a care home. A domiciliary care agency provides personal care to people living in their own homes. Under this arrangement people's care and housing are provided under separate contractual agreements. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. In this case the Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Hazeldene House is registered to provide nursing, personal care and accommodation for up to 75 people, and at the time of the inspection there were 74 people living there. Most people were receiving personal care from staff and had rented their accommodation within Hazeldene House. They also received support from nurses who were employed by the registered provider under a separate agreement. Ten people received both accommodation and care as part of one agreement. The service provided support to older people with dementia. It was arranged over three floors, with each floor having its own communal lounge area.

The service had a registered manager. 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.

Action was not always taken to protect people from risks once they had been identified. Risk management strategies were not always being followed by staff. There was insufficient guidance provided to staff in order to manage the risks. There were not always enough staff available to meet the needs of people at the service. This had an impact on the safety of people living at the service. People were not being protected from abuse. The registered manager had not followed up on all safeguarding concerns reported to them. The registered manager had failed to notify us of a notifiable event in a timely manner.

Some staff were not always able to communicate with people or their relatives in a way they could understand, because the staff did not always understand spoken English. We made a recommendation about this. We saw more positive interactions between other staff and people. People were encouraged to take part in the reviews of their care and relatives had access to up-to-date information about how people were being supported. However, the registered provider was not always providing information to people in a way they could understand. We have made a recommendation about this. People were supported to be independent.

People's needs were assessed but their care was not always delivered in line with current legislation. When the service was responsible, people were supported to eat and drink enough to maintain a balanced diet.

Appropriate referrals were made to health professionals such as speech and language teams. However, staff were not always following guidance when it had been provided. Staff received training which ensured they had the skills and knowledge to deliver effective care. 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.

People received their medicines safely. People were protected by the prevention and control of infection. The service was clean and smelt fresh.

People received care that was responsive to their needs. Relatives told us they knew how to complain, and would be happy to do so if they had any issues or concerns. However, complaints were not always treated as such, and we made a recommendation about this. There was nobody receiving end of life care at the time of the inspection, but staff knew how to support people if they needed to in order for people to have a pain free and dignified death. People, their families and staff were encouraged to be involved with the service. There were links with the local community, including the Alzheimer's Society and the local hospice.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of Care Quality Commission (Registration) Regulations 2009. Full information about the Care Quality Commission's regulatory response will be added to the report after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Action was not always taken to protect people from risks. When risks were identified they were not always effectively managed.

People were not always protected from the risk of abuse because the registered manager had not taken adequate steps to follow up on concerns raised with them.

Lessons were not being learned when things went wrong.

There were not always enough staff to meet the needs of people living at the service.

Medicines were being managed safely.

People were being protected from the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always following guidance from healthcare professionals and ensure people had access to health care and treatment.

People did not always have their care delivered in line with current legislation and best practice guidance.

Staff had the skills and experience to meet people's needs.

People's nutrition and hydration needs were met.

Staff knew how to seek consent from people and were knowledgeable about the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always communicate with people effectively or in a way they could always understand.

People were supported to express their views and were actively involved in making decisions about their care.

People's independence was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not receiving information in an accessible way.

People's care was provided in a personalised way.

People were supported to take part in activities that interested them.

People told us they were confident to raise complaints about the care and support they received.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not notified CQC of all significant events.

Governance systems were not always effective in ensuring shortfalls in service delivery were identified and rectified.

People, their families and staff were encouraged to be engaged and involved with the service.

There were strong links with the local community.

Hazeldene House

Detailed findings

Background to this inspection

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

This inspection took place on 12 September 2018, and 15 and 16 October 2018 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor nurse and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

The additional two days of inspection were prompted in part by notification of an incident. This inspection did not examine the circumstances of the incident; however, the information shared with CQC about the incident indicated potential concerns about the management of safeguarding. This inspection examined those risks.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also used information the provider sent us in the Provider Information Return (PIR). 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 observed the care provided for people. 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. During our inspection we spoke with two people about what it was like to live at the service. We spoke with five relatives. We spoke with fourteen staff members which included the registered manager, their personal assistant, the deputy manager, three nurses and eight care workers.

We looked at risk and quality audit records, policies and procedures, complaint and incident and accident monitoring systems. We looked at six people's care files, ten staff recruitment files, the staff training programme and medicine records.

Inadequate

Is the service safe?

Our findings

People's relatives told us they felt the service was safe. One relative said, "She is absolutely safe. She's been here for three years and often tells me she feels very safe." Another commented, "Much safer than at home." A third told us, "He has an alarmed floor mattress. As soon as he attempts to get out of bed they come quickly." However, despite these comments we found the service was not always safe.

Potential risks were identified but they were not always effectively managed. There were a significant number of incidents and accidents being recorded in people's care records. This included people falling and episodes of aggression from people who had behaviour that challenged due to their dementia. Where risks were identified they were recorded in the person's care records. However, guidance provided to staff was not always kept up-to-date, was not detailed and did not always prevent further incidents occurring. For example, one person's care records indicated they were at risk of falling. Records also showed they had fallen eleven times in the three months prior to our inspection. Four of these were recorded in the person's risk assessment, on 18th August, 1st September, 29th September and 4th October 2018. On each occasion the strategy to prevent further falls was for care staff to closely monitor the person. However, this was shown to be insufficient in preventing the person from further falls.

In one person's records we saw that after a review of their risk assessment staff were advised they needed to monitor the person closely as there was a risk they might express challenging behaviour towards other people. However, one evening it was recorded that they had pushed over another person in the communal area. This altercation was heard by a nurse on duty, who at the time was in the office area. The two staff members on shift that day were elsewhere on the floor, which meant the person was not being monitored as needed in order to keep people safe.

Another person's records indicated they had been involved in seven incidents in the five months prior to the inspection where they had initiated an altercation with either a staff member or another resident. On one occasion staff were alerted to them being in another person's room whilst that person was sleeping. The deputy manager told us a sensor mat next to the person's bed was activated, so alerted staff, who were able to take prompt action. Although the incident was recorded in the person's care records, and a referral was made to a health professional to assess the new behaviours, clear guidance was not provided on how staff were to protect others in the service from the risk of harm.

The registered manager kept logs of incidents and accidents happening at the service. They informed us the logs were reviewed each month to look for trends and patterns so action could be taken to keep people safe. They said they use the incident reports to inform them of what action was needed. However, the registered manager was not able to tell us about any lessons that had been learnt, and care records showed lessons had not been learnt on all occasions as incidents involving people repeated with no other action being taken. Additionally, not all incidents and accidents were being reported by staff in line with established procedures. One person's records showed they had fallen four times, but only two had been reported as an incident or an accident. This meant the registered manager did not have complete oversight of all incidents and accidents happening at the service.

The failure to assess and take steps to reduce risks to people's health and safety was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse. The registered manager had not taken adequate steps to follow up on some of the concerns raised with them. The registered manager kept a log of safeguarding concerns which showed the actions taken, such as reporting the concerns to the local authority, and assisting in investigations. However, the logs did not provide a complete oversight of the safeguarding concerns being raised at the service as not all safeguarding concerns were being recorded as such. We were concerned to find some potential safeguarding issues had been discounted by the Registered Manager and senior staff when they were raised by relatives. The registered manager had also not formally notified the local authority about some allegations. They should inform the authority's safeguarding team about any allegations so health and social care professionals can decide how best to protect people from further abuse. Neither had the registered manager informed the Care Quality Commission about the allegations as is a requirement of their registration. This meant we were unable to take steps to help keep people safe.

The failure to ensure that people were safeguarded from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to keep people safe from identified risks. The registered manager told us they used a dependency tool to calculate the number of staff needed on each shift. Additionally, the deputy manager and a registered nurse told us they could request an increase in staffing levels if they felt the needs of people had increased. Records confirmed that after one such request, staffing numbers for the afternoon shift in one unit was increased from four to five staff members. Also, if additional staff were needed in order to respond to people's needs urgently, staff were able to call for assistance from other floors or could press an emergency button which would call on staff who were on their break in the staff room. However, we found that despite these procedures being in place, people remained at risk of harm because there were not enough staff to follow the risk management strategies identified in people's care records.

The failure to deploy a sufficient number of staff to meet the needs of those using the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff were recruited safely. Recruitment files contained information showing the applicant's full employment history. References were sought and checked. A Disclosure and Barring Service (DBS) check helped inform the registered manager's decision about the suitability of the candidates. A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with vulnerable people.

People received their medicines safely and as prescribed to protect their health and wellbeing. The policy on the administration of medicines followed published guidance and best practice. Nurses were trained to administer medicines and their competence was checked by the registered manager against the medicines policy to ensure good practices were maintained. Medicines were stored safely in temperature controlled rooms within lockable storage containers. Storage temperatures recorded were within recommended ranges to maintain the effectiveness of medicines. Nurses described how they kept people safe when administering medicines. 'As and when' required medicines (PRN) were administered in line with the provider's PRN policies.

The risks to people from foreseeable emergencies were minimised. Staff had training in fire safety and

practised the fire evacuation routine. Evacuation response times were recorded and staff involved were debriefed to improve practice and understanding. Each person had their own individual evacuation plan, which showed the support they needed in the event of an evacuation. Contingency plans were in place to show how people's care would continue in during and after emergencies, for example after fire or flood.

People were protected by the prevention and control of infection. The service had a policy in place and staff followed Department of Health guidelines which helped minimise risk from infection. There was an infection control champion, whose role was to make sure staff followed the guidelines and policies. Staff said they had access to protective equipment like disposable gloves, and people confirmed they saw staff using them. The environment was clean and smelt fresh. One relative told us, "It's the same standard as a first class hotel. The place is so spotlessly clean."

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought staff were skilled to meet their needs. A relative said, "The staff are very good they know what they're doing." Another relative said, 'The food is very good, choice always a vegetarian or meat dish."

Staff were not always following guidelines to ensure people's health needs were being met. One person was at risk of a health condition if they remained in the same position in bed for a long period of time. The person's care records indicated they should be repositioned at a particular frequency to minimise the risk of harm. The registered manager told us there was an expectation this should be recorded by staff as and when the repositioning took place. We saw the care records were not always being completed as expected, with staff completing some records a number of hours after the event. Additionally, we found staff were not repositioning the person as often as was needed. During one eight-day period there were nineteen different occasions where the person waited to be repositioned for more than the required frequency, with a five hour wait on one occasion and four hour waits on four occasions.

The same care records also showed a hospice nurse had advised that since the repositioning was causing the person discomfort, staff only needed to take action if there was a clinical need. However, records showed the frequency had actually increased the day following the advice, with no record as to why this was needed. Lastly, we found inconsistencies with records for one day, as there were two different records being completed by staff for one day. These records showed the person had been repositioned twice as often as was needed at a time when staff had identified the person had been in discomfort when it was taking place.

The failure to provide care that meets all a person's health needs was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed but their care and support was not always delivered in line with current legislation. Each person's needs were assessed before the service commenced to make sure staff could meet them. The assessments considered people's emotional and physical health needs, such as the support they needed with communication. However, these communication needs were not always met by staff because some staff were not able to understand what was being spoken to them. Their protected characteristics under the Equalities Act 2010, such as their disabilities and religious or cultural needs were taken into consideration. The assessments also took into account national evidence-based guidance when assessing peoples risk of pressure wounds, malnutrition and pain.

Staff had the skills and experience to provide effective care and treatment. Newly recruited members of staff were supported by an induction into the service. Those who didn't have a background in care were working towards the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Established members of staff were supported with training, which was monitored by the registered manager

to ensure they kept up-to-date. Practical training such as moving and handling or basic life support was provided face to face. Other training, such as infection control or equality and diversity was provided online. Nurses and care staff informed us that they had received appropriate training to carry out their roles. Staff told us they thought the training was good quality and enabled them to carry out their roles with confidence. When people had specialist health conditions additional training was provided, such as for wound care or training to support those with dementia.

The registered manager supported nurses to maintain their registration with the Nursing and Midwifery Council. Staff were trained and understood how to manage behaviours that may challenge. The registered manager met with staff for supervisions and an annual appraisal. This gave staff the opportunity to discuss what had gone well for them over the previous year, where they had weaknesses in their skills and enabled them to plan their training and development.

People were supported to eat and drink enough to maintain a balanced diet. The registered provider employed an in-house nutritionist to support people's dietary health and wellbeing and meals were well balanced. People could choose to have their meals in their room, at the dining table or in the communal lounge. Menus were prepared in advance, and people had a choice of what to eat at each mealtime. If they did not like anything on the menu they could choose to have an alternative, such as an omelette or jacket potato. People could choose to have meals at the time they wanted. One person chose to get up later than others in the morning. We saw them having both cereal then a cooked breakfast an hour after everyone else had finished their breakfast. Mealtimes were relaxed and people were not rushed to finish their food. The portions were generous and were hot when served. People were encouraged to eat independently if they could. One person sitting at the table put their plate on their lap and continued to eat off it. Staff did not interfere with them, and they went on to finish their meal.

Staff were aware of people's specialist dietary needs. When one person had been assessed to be at risk of choking, staff were able to describe the action they would take to help keep them safe, such as encouraging them to eat slowly. Other people at risk of malnutrition had their weight monitored regularly and staff followed guidelines to make sure they had enough to eat. One person's care plan indicated they needed to be encouraged to eat snacks between meals for them to maintain their weight. Records showed staff had successfully supported them to eat snacks, and their weight had been stable for the three months prior to our inspection.

The premises were adapted to meet the needs of people living with dementia or poor mobility. The internal and external parts of the premises were easily accessible. One relative told us, "There's lovely grounds. I can take mum out and wander in the gardens. They are well thought out." Different areas of hallways and communal areas were identifiable with different colours of flooring and signage was used to assist people to orientate themselves. People were supported to find their way around the service. We saw arrows had been placed on the wall to assist a person to find their way back to their bedroom independently. People could choose which room they wanted before they moved in. They were also able to adapt their rooms if they wanted to, and one person had been supported to bring in their own furniture form their home to help make them feel more comfortable.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

In care homes, people can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In supported living services, applications for restrictions of liberty must be made to the Court of Protection.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. Most people living at the service had dementia, and we found staff to be knowledgeable about the MCA, and were following its principles. For example, one person had been refusing to take their medicines. Staff found them not to have the ability to make decisions about their health care, so arranged for a meeting with the family and health professionals. During this meeting it was decided the person should have their medicine covertly in yoghurt. This decision was recorded in the person's care records.

Requires Improvement

Is the service caring?

Our findings

A relative said, "Staff are definitely caring, when [relative] was poorly last week a lot of staff were going into his room to get him to eat something, it took 20mins to eat a spoonful of jelly. Staff are very caring talking to people. She loves a foot massage and they do that." Another relative said, "It is without question that we as a family have to praise all the staff for their help, courtesy and caring nature." However, these positive comments notwithstanding, we did not always find the service to be caring.

Staff did not always communicate with people effectively or in a way they could always understand. A number of staff working at the service were from eastern Europe, and English was not their first language. Some of these staff had difficulty in speaking or understanding basic English. On one occasion we wanted to talk to a member of staff about how they treated people with dignity and respect. They told us they could not understand what we were asking, so we needed to ask another staff member to translate for us, which they did. We then watched the staff member support a person in the communal area. We saw the person trying to talk to the staff member and we saw the staff member did not respond to them, which implied they did not understand what was being said. Eventually the person seemed frustrated as they gave up trying to be understood. On another occasion we saw a member of staff talking with a resident, who started speaking really slowly to try and get themselves understood. At one point they were asking a question, trying to get a response but the carer could not give a response. On another occasion we asked a staff member which people we could speak to as part of the inspection, and we were told they could not answer as they could not speak English.

The failure to ensure that people received care from staff that met their needs and reflected their preferences was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us the difficulties some staff had with English had an impact on the support they and their loved ones received. One relative told us, "The language barrier is an issue. We notice that new staff can't speak any English at all and takes them at least 6 months to learn a little." During our inspection we heard a number of conversations taking place between staff which people or their relatives could not understand as they were not being carried out in English. A relative said, "It is sometimes difficult for me to understand as they are mostly eastern European. They do speak in their own language if they need to say something to each other, but they speak to residents in English."

We spoke to the registered manager about our concerns. They told us they acknowledged the language barriers might cause some difficulties, and said they sometimes use senior staff to translate at, for example, team meetings. However, they said they were taking steps to address the concerns by asking staff to complete English lessons to further develop as part of their training.

Although some people and relatives had difficulties communicating with some staff, we saw other more positive interactions between staff and people in the lounge and in the communal areas. We saw staff listening to people, trying to find out what they wanted. For example, one person wanted to sit outside the

dining room at lunch time, staff understood this and her lunch was served there. When speaking to people staff got down to eye level with the person so that the person could clearly see them and staff used eye contact and caring gestures, like a gentle touch on the arm to reassure people. Staff used people's preferred names when addressing them. We observed that one person had fallen asleep in their arm chair in the lounge with their head on the arm of the chair. A member of staff went and got a pillow to support the persons head to make the person more comfortable.

Staff were polite and cheerful, and created a friendly atmosphere in the service. Staff said please and thank you to people when they spoke to them asking them to carry out a task. Staff told us they 'try to explain' as much as possible to people, especially during personal care. One member of staff said, "The person might be afraid, I would listen, and talk with them or ask a colleague or the nurse to help." One member of staff said, "People are treated like our own Mum and Dad."

When possible, people made choices in relation to their care. For example, at lunch time we saw that staff took foods on plates to people to show them before they made a final choice. Where people were living with dementia their care plans demonstrated that family members were involved in the development of their loved ones' care plan. Staff were aware of people's preferences when providing care. Three different staff told us how they involved people in their personal care by offering choices in what toiletries and clothes they would like to wear.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they thought the service provided care and support that responded to the needs of those living there. One relative told us, "They do so much here, and the activities are great." Another said, "If I had a complaint I would see the nurse of the manager. But I haven't had anything to complain about." However, we did not always find the service to be responsive.

People told us they were aware of how to make a complaint, and felt confident to do so if they felt they needed to. People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. However, we found instances where people had raised concerns about the treatment of their loved ones which had not been dealt with either as a complaint or, more appropriately, as a safeguarding issue. Others had more positive experiences of the complaints process. One relative told us that when they did complain these were dealt with quickly and appropriately. Two other relatives told us how complaints they had made had been resolved to their satisfaction.

We recommend the service seeks guidance from a reputable source about the management of complaints.

The registered provider was not always meeting people's communication needs because it was not meeting all of the Accessible Information Standard. The Standard was introduced on 1 August 2016 and sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such as large print and graphics. The registered provider had identified and recorded people's communication needs as required by the standard. Some needs were being met, such as signage being provided in a format accessible to those with dementia. However, the registered provider had not taken sufficient steps to ensure information such as care plans were available to them in a format they understood. People's care plans, which recorded the support they had consented to, were available electronically by accessing a password protected database. The registered manager confirmed they had not been made available in a format such as on video or other methods which might help people understand them.

We recommend the registered provider seek guidance from a reputable source regarding providing information to people in a way they understand.

However, people's care was delivered around their needs and choices. Each person had their own care plan which gave clear details about their needs and how they liked to be supported. Sections included family, places and occupations. Care plans contained information on a range of aspects of people's needs including mobility, communication, emotional wellbeing and specific dementia support. Plans were reviewed and updated monthly or as and when people's needs changed, such as when people's mobility changed or they needed more prompting to manage personal care. Staff met with people to discuss their care. Where people were not able to be involved in these reviews records showed that care had been discussed with relatives and professionals, where appropriate, and decisions made were based on people's

life history and previous preferences.

People were being supported to follow their interests and took part in activities which met their needs. To promote wellbeing and reduce isolation activities were planned and coordinated by activities coordinators based on each floor. Activity logs were completed to record when people chose to participate, we could see which people had attended which activities and it showed all were being included. We observed a chair based exercise activity which people seemed to be enjoying as there was lots of laughter. A music and dancing session involving people in a different unit was clearly being enjoyed and most people in the unit joined in. People who did not want to join in were supported in smaller groups, such as one group of three people being supported to draw a picture. People who preferred to stay in their rooms were visited by an activities co-ordinator for one-to-one sessions including being read to. Activities coordinators also supported people to maintain their interests outside the service. For example, one person with an interest in vintage cars had been supported to visit a vehicle museum.

Nurses had specific skills and training around end of life care to enable people to have a pain free and dignified death. No end of life care was being delivered at the time of this inspection. However, people's wishes for their end of life had been documented in care plans. People also had a section in their care plan detailing how any pain they may be experiencing should be managed. Staff worked closely with a nearby hospice to support people at the end of their life to make sure people receiving end of life care were supported with dignity. A relative had complimented the end of life nursing staff at the service had provided recently. They said, "Will be for ever grateful I was allowed to share so many moments of my dad's end of life care. I would never have got though those last days without you, deep respect you are a wonderful nurse."

Inadequate

Is the service well-led?

Our findings

People's relatives told us they thought the service was well-led. One told us, "It's well managed, I couldn't find a better home for him." Another said, "It's fantastic. Everyone who comes to visit from the family are overwhelmed." A further relative commented, "She's very experienced in dementia and a good manager. They have always been helpful when I've had a concern." Nevertheless, we did not always find the service to be well-led.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, they were not aware of all of their responsibilities to ensure compliance with fundamental standards and regulations. We found they had failed to notify CQC of notifiable events in a timely manner.

The failure to notify us of significant events occurring in the service were breaches of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had not always acted in a transparent and candid manner. For example, we received a complaint from a relative that the Food Hygiene rating, given by the Food Standards Agency (FSA), had been revised from a score of five to a score of one following an inspection in August 2018. They raised concerns that the home continued to display the rating of five. When we spoke to the manager about these concerns they told us the rating was not on display as the FSA no longer sent out stickers. However, we received photographic evidence that the sticker had in fact been in place at the entrance of the service for at least two months after the rating was changed.

We also spoke to the manager about the reasons for the change in rating, and were told that a staff member had not known where particular paperwork was kept during the inspection, but that the paperwork was subsequently found and there were no concerns relating to food hygiene at the service. However, when we requested a copy of the FSA's report we saw it actually contained other concerns relating to the food hygiene in the kitchen. These included the operation of equipment and concerns that staff were not identifying to managers when fridge temperatures were too high, in line with established procedures.

The registered manager told us systems were in place which continuously assessed risks and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents. Additionally, a quality oversight system was used, which was independent of the service, to provide organisational monitoring of the service against the provider's aims and principles. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. We found, however, that when relatives did raise issues these were discounted by staff. Relatives had commented the registered manager was dismissive of their concerns and staff attributed peoples' comments to their mental health needs. The registered manager told us they felt it was a transparent service where staff would raise any concerns with them, such as any safeguarding concerns,

however we did not find this to be the case. Neither the registered provider or the registered manager had sufficient oversight as these systems and processes did not identify all the areas of concern we identified throughout our inspection, such as how incidents and safeguarding concerns were being managed.

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating in the service and on their website.

The registered provider continued to seek people's views and took action to improve their experiences. There were resident and relative's meetings. One relative said, "They have friends and families' meetings, if I see something not right I will tell the manager." Relatives during one recent meeting highlighted that ironing was taking a long time to get back to the person's room. Records showed the registered manager had employed a staff member specifically to do the ironing, and as a result relatives reported a great improvement in turnaround times. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The overall scores were analysed by the provider and responded to. For example, people wanted improvements to the activities and the registered manager had responded by deploying an activity organiser on each floor of the service. They were also reviewing the financial resources available for activities. We were told any improvements would be checked at the next survey.

Records demonstrated that there were regular staff meetings at the service and hand over meetings between shifts. Night staff meetings also took place. Weekly nurse clinical meetings took place to monitor people's health progress. Agendas at meetings included a 'topic of the month', for example discussing whistle blowing, mental capacity or recording challenging behaviours. Staff meetings also included information for staff about risks management and health and safety. Staff continued to receive appropriate supervision and told us that the registered manager was supportive and that they were listened to.

The service worked in partnership with other agencies in the local community to enable people to receive 'joined-up' care. When the registered manager had informed the local safeguarding team about safeguarding concerns, they worked with them in a transparent manner. They also worked with care managers, GPs, and other health professionals when needed. Staff worked closely with the local hospice, and there were links with a local church who visited to carry out a regular service for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were sufficient numbers of staff deployed to meet people's care needs Regulation 18 (1)