Regal Care Trading Ltd

Moorlands Care Home

Inspection report

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22 May 2019

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:
Moorlands Care Home, 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.

Moorlands Care Home accommodates up to 40 people in one adapted building. At the time of the inspection there were 27 older people, some people were living with dementia or had nursing needs.

People's experience of using this service:
There were insufficient staff to meet people's needs. Staff had not undertaken sufficient or appropriate training to enable them to meet the needs of people living with dementia and those who had behaviour that challenges. This meant there was potential for people's safety, health and welfare to be at risk. Staff underwent a robust recruitment process. People were kept safe by staff who understood how to safeguard people from abuse and the actions they needed to take to protect people from the risk of harm. People's medicines were managed safely.

People's views about how they were treated, and the approachability and availability of staff was linked to staffing levels. People told us they sometimes felt rushed and that staff didn't have time to sit and speak with them. People and family members stated staff were kind and caring and we saw examples of positive interactions between people and staff. People told us they were consulted about their care and that they were encouraged to make decisions. The service had received many thank you cards praising staff for the quality of care provided.

Staff had requested additional training in specific topics and had asked for a different method and style of training to be provided. People were supported to have sufficient amounts to eat and drink and were provided with the appropriate specialist diet where required. Staff supported people to maintain their health and well-being, which included liaising and working with a range of health care professionals, which had positive outcomes for people. 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.

There were opportunities for family members to be involved in their relative's care, which included end of life care. Activities were provided, however not everyone chose to join in and some people said there were limited opportunities to go outside. Accessibility of information and communication styles were considered to support people in understanding key information. People were confident to speak with staff about any issues of concern to them.

The registered manager had requested additional resources to provide classroom-based training and training in key areas to drive improvement. The provider had systems in place to monitor the quality of the

service with audits were undertaken on a range of topics. Information agreed to be forwarded to the Care Quality Commission following the site visit was not received. People, family members and staff were given the opportunity to comment upon the service. The registered manager and staff liaised and worked with partner agencies to support people in the best way possible.

Rating at last inspection:
Good. The last report for Moorlands Care Home was published on 5 October 2016.

Why we inspected:
This was a planned comprehensive inspection.

Enforcement:
We identified a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to staffing. Details of action we have asked the provider to take can be found at the end of this report.

Follow up:
We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with our inspection timescales for Requires Improvement services

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

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 always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Moorlands Care Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was carried out by one inspector, a Specialist Advisor (the Specialist Advisor had experience working and caring for people who require general nursing care) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Moorlands Care Home is a care home, which provides nursing care.

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

Notice of inspection:
The inspection site visit activity took place on 21 May 2019 and was unannounced. We returned on 22 May 2019 announced.

What we did:
We used the 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.

Our planning took into account information we held about the service. This included information about incidents the provider must notify us about, such as abuse; and we looked at issues raised in complaints and how the service responded to them. We obtained information from the local authority commissioners.

We spoke with nine people and three visiting family members.

We spoke with the registered manager, a nurse, the regional manager, a chef and seven members of the care staff team, some of whom were 'champions' in key topics, which included nutrition. We spoke with two visiting health care professionals.

We looked at the care plans and records of six people. We looked at three staff records, which included their recruitment, induction, training and on-going monitoring. We looked at the minutes of staff meetings and records related to the quality monitoring of the service, which included minutes of meetings and the findings detailed within questionnaires sent out by the provider to people using the service, family members and staff.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Staffing and recruitment:

- People we spoke with told us there were insufficient staff. One person told us, "There is not enough staff, there should be more." A second person said, "There is definitely not enough staff." "A third person said, "They [staff] sometimes take a while when I press my buzzer."
- Family members told us there were insufficient staff. A family member said, "There are not many staff at weekends and after 7pm." A second family member said, "[Relative] is isolated upstairs. There are times when you can't find a carer."
- Staff raised concerns with us with regards to insufficient staff being on duty to meet people's needs and keep them safe. Staff said they had to be vigilant and monitor people who chose to remain in their bedroom and balance their care needs with those who chose to sit in the lounge. Staff said they could not always meet people's needs, when people required the support of more than one member of staff. For example, when having to use equipment to move people and to support people, when they became anxious or distressed to maintain their safety.
- Insufficient staffing meant people's needs were not always met, which had the potential to compromise safety and well-being. Staffing levels were not calculated based on the individual needs of people. Hours were instead allocated on a weekly basis based on the number of people using the service and whether they did or did not have dementia or received nursing care.
- Staff rotas did not reflect the needs of people using the service. For example, additional staff were not on duty at key times of the day. People living with dementia often experience 'sundowning'. (Sundowning is a term used for the changes in behaviour that occur in the evening, around dusk and may result in the person shouting, arguing, pacing or becoming increasingly confused). We observed a person becoming distressed when staff needed to provide essential personal care which meant the person needed to move from the lounge area, which required the support of the four care staff on duty, as detailed with the person's care plan. Other people sitting in the lounge became distressed and anxious and walked around with wheelchairs and walking frames, with insufficient staff to reassure or support them. A second person who required support with personal care had to wait, as staff were supporting the other person.

The provider failed to ensure there were sufficient numbers of skilled and experienced staff to meet people's needs.
This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people. This included a completed application form, a full work history, references and a record of their interview.

● Prior to commencing in post staff had a Disclosure and Barring Service check (DBS). The DBS assists employer to make safe recruitment decisions by ensuring the suitability of individuals to care for people. Records were in place to evidence nursing staff were registered with Nursing and Midwifery Council (NMC), which meant they were registered to provide nursing care safely

Systems and processes to safeguard people from the risk of abuse:
● People we spoke with told us they felt safe. One person said, "I feel safe because lots of people are here." A second person said, "I feel safe because the doors are locked, and no one can get in." A third person said, "Staff come in and speak to me, makes me feel safe."
● There were safeguarding and whistleblowing policies and procedures to guide staff on what action to take should they have any concerns. These are laws that protect whistle-blowers from being unfairly treated for reporting misconduct.
● Staff were clear in their discussions with us that they would have no hesitation in alerting the registered manager or a nurse should they have any concerns about a person's welfare.
● The registered manager referred safeguarding concerns to safeguarding teams and informed other relevant organisations such as the CQC.
● Information about safeguarding was displayed on a notice board within the service.

Using medicines safely:
● People told us they received their medicines, which included medicine when they needed it. One person said. "Staff would give me something for pain if I need it." A second person said, "I have my medication and they make sure that I take it, and they never forget to give it to you."
● A few people had been prescribed medicines which had to be taken at specific times, we found that the time the person took the medicine was not recorded. This was important to ensure people had something to eat within a set timeframe of them taking their medicine. We spoke with the nurse and registered manager who told us they would take immediate action.
● People's medicine was managed safely and records we viewed confirmed this. There were clear protocols for the management and administration of medicine which were adhered to. People's health care records reflected their health was monitored in response to medicines prescribed. People's records detailed the frequency and dosage of their medicine and how it was to be administered and included information about any allergies.
● There were clear protocols in place for people who were prescribed medicine to be taken as and when required. Nurses were observed administered medicines safely, people were asked if they required medicine to alleviate pain and information was given to people about the medicine they were taking.
● A medicine policy and procedure was in place, which was linked with good practice guidance and legislation. This included guidance on the action the service was to take when people did not have the capacity to make an informed decision about the administration of their medicine.

Preventing and controlling infection:
● An independent infection control audit had been undertaken and shortfalls identified, not all the shortfalls had been actioned. The monitoring of the actions will be kept under review by the independent organisation who undertook the audit.
● A family member told us, "I think that it is clean and well-maintained."
● Staff were seen to wear personal protective equipment (PPE) including gloves and aprons when they supported people with personal care and when serving meals and drinks.
● Policies and procedures on preventing and controlling the spread of infection were in place.
● Staff underwent training on the prevention and controlling of infection.

Assessing risk, safety monitoring and management:

● Family members were aware of how their relative's safety was promoted, which included the use of equipment where appropriate. One family member said, "The floor is nice and flat and no clutter for them [people] to walk around." A second family member said, "[Relative] has safety rails on the bed and a movement sensor in the room. That makes us feel safe."

● Potential risks to people were assessed and regularly reviewed with regards to their personal care. For example; falls, skin integrity, nutrition, mobility, eating and drinking were assessed.

Equipment was in place to minimise risk and meet people's health needs.

● Staff from the service worked with the community therapy team, as part of a targeted initiative to reduce the number of falls people have within care settings.

● We spoke with the physiotherapist from the community therapy team who confirmed people at risk of falls had been referred to the service. They told us collaborative working between the team and staff of Moorlands Care Home had reduced the number of falls for those identified at risk. This had been achieved by implementing practical changes to meet people's specific needs and reduce risk. For example, by leaving the light on in the en-suite at night or moving the location of the bed within a room.

● Potential risks to people were assessed and regularly reviewed with regards to their mobility. Equipment to meet people's needs and keep them safe was provided, this included equipment to support people to have a bath or shower and move about the service independently.

● An individual risk assessment had been undertaken which identified the level of risk to the person should they be required to evacuate the service in an emergency.

Learning lessons when things go wrong:

● Staff were aware of their responsibilities to raise concerns and record safety incidents. Incidents were used to improve people's care. For example, each fall a person experienced was documented and timely referrals were made to external health care professionals to reduce further falls.

● Nursing staff met regularly, to talk about updated guidance and identify whether any action was required.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience:
● Staff accessed training in key areas which included first aid, continence care, fire awareness, infection control, moving and handing people safely using equipment and falls awareness. Training in specific areas for the promotion of people's health and welfare was also provided by health care professionals.
● Staff told us they would prefer the opportunity to attend additional 'classroom' style training as this method of training enabled them to process information and provided an opportunity to ask questions. The registered manager told us they had spoken with the provider about staff's request for alternative methods of training.
● Staff told us they had received training in dementia care. However, some staff said they did not feel sufficiently confident or knowledgeable to support people living with dementia or when their behaviour became challenging.
● The registered manager acknowledged additional training was needed in dementia care and in caring for people when their behaviour was challenging and confirmed staff had requested additional training. The registered manager told us they had requested additional resources from the provider to enable staff to access the relevant training. At the time of the inspection the registered manager advised no additional training had been made available.
● Staff received support through supervision and appraisal to enable staff to review and discuss their work practices. Opportunities were available for staff to gain vocational qualifications in health and social care.
● Nursing staff evidenced their continued professional development to maintain their registration with the Nursing and Midwifery Council (NMC). Nursing staff underwent regular informal clinical supervision and met regularly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● People's needs were assessed by commissioners who fund people's care and by the registered manager. Assessment had been carried out consistent with the Equality Act to ensure there was no discrimination when making decisions as to people's suitability to move to the service. The assessment process covered all aspects of people's health, care and well-being.
● Assessments included seeking information about a person's life. We saw some people's records contained information about their family life, working life, hobbies and interests.

Supporting people to eat and drink enough to maintain a balanced diet:
● People spoke positively about the food. One person said, "The food is good, and they give you a choice." A second person said, "The food is very good; I am on a special diet I miss my proper food but what they provide for me is nice." A family member told us, "The food looks fresh and nice and they have pictures of

the food on the tables at lunchtime."
● People in some instances ate in the dining area of the lounge, whilst others ate from a comfy chair in the lounge or their bedroom. Staff provided one to one support for those who required assistance to eat and drink.
● People were provided with adapted plates and bowls to enable them to eat independently. Plates, bowls and cups were provided in a range of colours to help people see the food more easily and is recognised to support people living with dementia.
● The chef was provided with information as to people's dietary requirements and preferences. The chef told us that meals and foods, such as cakes were homemade. Seasonal menus were in place, and people's views about meals were sought through questionnaires.
● Food and drink was accessible to people and visitors. Staff were seen to regularly serve refreshments throughout the day, which included hot and cold drinks.
● Assessments identified people's needs with regards to food and drink. Specialist diets to meet people's needs were provided. For example, diets to support medical conditions such as diabetes.
● Risk assessments identified people at risk in relation to eating and drinking so that measures could be put into place to ensure people had sufficient to eat and drink. For example, those at risk of poor food intake and who were noted to be at risk of losing weight were provided with a fortified diet. People at risk of choking were given a soft diet and thickened fluids as recommended by a Speech and Language Therapist to minimise the risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
● People confirmed they were supported to maintain their health. One person said, "I see my own optician if I need too." A second person said, "The nurse is very good if you have a problem." A third person said, "I see the GP, chiropodist, optician, physiotherapist and dentist."
A family member told us, "The district nurse comes in to change a dressing for my [relative].
● People had access to a range of health care services. During our site visit, we saw community nurses, a physiotherapist, an occupational therapist and doctors visiting to review people's care and respond to changes in people's health.

Adapting service, design, decoration to meet people's needs:
● A person told us, "They let you bring in personal things which makes it homely." A second person said, "They [staff] decorate your room to celebrate your birthday and at Christmas."
● Signage was in place throughout the service to help people in finding their way around. Signage was in a pictorial and word format, and included signs advising people as to the route to communal rooms, toilet and bathing facilities.
● The lounges were furnished to help people living with dementia, by providing areas of interest for people to look at and objects for them to interact with. For example, a cradle with a doll, soft toys, building blocks and small items many people would have in their own home.
● There was a television in the main lounge, however we were told this was not often on as people living with dementia at Moorlands Care Home preferred to listen to music. During out inspection we saw people tapping their feet to the music.
● The service provided equipment to support people's independence and the meeting of people's personal care needs.

Ensuring consent to care and treatment in line with law and guidance:
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 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People's capacity to make informed decisions about their health, care and welfare were assessed. Where assessments had identified people did not have the capacity to make an informed decision, then a best interest decision was made on their behalf. Best interest decision meetings involved health care professionals and family members.
- A number of people at the service, who did not have the capacity to make an informed decision had an authorised DoLS in place, which placed restrictions on them, for example leaving the service without being accompanied, as this would place the person at risk.
- Staff had received training on the MCA and our observations showed that staff always sought people's consent before providing care and support.
- We found staff to be knowledgeable about people's individual capacity to make day to day decisions. We saw staff offered people a choice for example as to what they wished to eat or drink, where they wanted to sit or whether they wished to take part in an activity.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity: Respecting and promoting people's privacy, dignity and independence:

● People did not consistently feel well treated or supported, their views about their care was linked to the both the approach and availability of staff. One person said, "I am concerned that there is not enough staff, they don't have the chance to speak to me." A second person said, "They [staff] sometimes rush when they are giving me personal care." A family member said, some carers are caring; some don't seem interested."

● People praised the staff for their care. "I am well looked after, I need for nothing." A second person said, "Everything is done for me; they [staff] keep me lovely." A third person said, "I am always looked after, it's absolutely wonderful here." A fourth person said, "When I first came, I did not think they knew how to look after me, now I think that they do, and they are very nice."

● We saw examples of staff supporting people when they became upset or distressed, by using distraction techniques such as offering them a cup of tea and sitting and speaking with them.

● People's privacy was respected when a visiting health care professional spoke with people who were sitting in communal areas as a screen was provided. However, we saw times when staff were not able to provide sufficient reassurance and support as they were having to meet the needs of a number of people at the same time.

● People received personalised support to maintain their dignity, which included supporting people to maintain their personal appearance. A family member told us, "The hairdresser come in and does [relative's] hair."

● People were supported to maintain their independence and we saw several examples this. One person accessed the community independently. They told us, "I go out and about myself. I walk to the shops. I could catch the bus if it wanted too and go to the next village." Staff were seen to encourage independence by supporting people to walk with their walking aid.

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

● People told us they made decisions about day to days issues about their care. One person said, "I have a shower as often as I like." A second person said, "I choose what time I get up and mostly what time I go to bed."

● Staff at the service promoted continued contact with family friends. People received visitors throughout the day, with no restrictions being in place. A person told us, "Our visitors can come at any time." A second person said, "My daughter takes me out most weekends."

●There was information available to people on Advocacy services this was displayed prominently at the service. The registered manager told us a number of people received support from a Paid Persons Representative (PPR). (The role of the PPR is to support people who lack capacity to agree to the care being

provided to them that involves restrictions on their liberty as authorised by a Deprivation of Liberty Safeguard (DoLS).

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

● A family member told us staff from the service had spoken with them to find out information about their relative to enable staff to provide the appropriate care and support. They said, "They [staff] asked us what [relative] likes and dislikes."
● A family member told us they were involved in decisions regarding their relative. They said, "We ask questions daily in regard to [relatives] health and they have called us in the past to let us know changes."
● People and family members did not consistently have the opportunity to be involved in the planning of their care. One person said, "I know of my care plan and my daughters are told of any changes to my care plan." A family member told us, "I don't know of any care plan." The registered manager informed us that copies of people's care plans when they were reviewed were electronically sent to family members, however they acknowledge not all family members were able to receive information electronically.
● People's care plans reflected people's individual needs and the support they required.
● People had a plan 'day in the life of'. The plan detailed people's preferences for the day, from rising in the morning and information as to whether they enjoyed listening to music and their preferred activities. For example, one person's record stated. I like to get up early and go to the main lounge. I liked to walk around the home and I will lay down when I am tired. I enjoy entertainment and chatting. We met and spoke with this person and our observations were consistent with the person's records.
● People were supported to take part in activities with the support of an activity co-ordinator. An activity co-ordinator told us they supported people on a one to one basis, which included visiting people who stayed in their room. We saw some people having their nails painted by the activity organiser, whilst others occupied themselves watching television, listening to music, reading and completing word puzzles and quizzes.
● Not everyone had the opportunity to engage in activities of their choosing. People shared with us how they spent their day, and people's views were mixed when we asked about the availability of activities and their ability to access the community. One person said, "There are activities downstairs. I do my own upstairs in my room; I have my own things to do." A second person said, "When we have nice days they [staff] don't take us out for fresh air." A third person told us, "They used to take us out, but we are getting older and older; there is too many of us to take out." A fourth person said, "The lounge is too hot for me sometimes, so they [staff] put DVD's in my room for me."
● An activity co-ordinator told us that activities within the service including, cake making, arts and crafts. Entertainers also visit the service, which include performers of music and dancing, visiting animals, which have included a selection of reptiles. Activities to promote physical movement such as chair aerobics were also provided by an external organisation. The activity co-ordinator told us trips out were organised, which had included a trip to see a black and white film in Nottingham.
● The service understood people's information and communication needs. These were identified, recorded, and highlighted in care plans and shared appropriately with other professionals involved in people's care.

For example, information as to whether people wore glasses or hearing aids. Care plans also provided guidance for staff to promote effective communication, which included the use of clear words in short sentences to provide information or to pose a question.

● Information about the service was detailed within the 'Service User Guide'. The document was written in plain language and large printed supported by pictorial symbols to assist people in understanding the document.

End of life care and support:

● Opportunities for people and family members to talk about their wishes should they became unwell were provided.

● People's wishes were recorded and any actions as a result of their comments were actioned. For example, some people had in place a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). People's capacity to make informed decisions about DNACPR's were documented

● Care plans were in place for those people who were receiving End of Life care. End of Life care plans included information about any medicines prescribed to help support people any pain or symptoms them may experience.

Improving care quality in response to complaints or concerns:

● People were aware of how to raise concerns or complaints. One person told us, "I have no concerns or complaints." A second person said, "Why do I need to complain about anything, I absolutely need for nothing." A Family member said. "No concerns or complaints."

● Complaints and concerns had been investigated, outcomes of investigations were shared with the complainant. In a majority instances people had expressed a concern, which was dealt with, and the person stating they didn't wish to make a complaint. The complaints policy and procedure was displayed on a notice board within the service.

● The 'Service User Guide', included the providers complaints procedure and the details, including addresses and contact details for external organisations. These included the local ombudsman and the Care Quality Commission (CQC).

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

- Since the previous inspection of 11 August 2016, the manager had applied to the Care Quality Commission (CQC) to be registered as the manager and their application.
- Staff told us they were supported by the registered manager, who had an open-door policy. Staff told us the registered manager facilitated meetings, where information about the service was discussed. Staff said meetings were a balance of what was working well and what areas required improvement.
- The registered manager demonstrated a high-level awareness of people's lives, both prior to moving to the service, as well as their current needs and importance aspects of their lives, which included family members and relationships.
- People and family members knew who the registered manager was. One person told us, "I know who the manager is, and everyone here is approachable." A second person said, "I know who the manager is." "A third person said, "The manager occasionally comes in and talks."
- The registered manager understood the requirement of their registration with the CQC. They could explain what incidents needed to be referred to the CQC and why. This meant the registered manager operated in an open and transparent manner.
- It is a legal requirement that a provider's latest CQC inspection is displayed at the home where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the service and on the providers website.
- All policies and procedures were reviewed annually and referenced good practice guidance.
- The provider had a business continuity plan in place, which detailed how the people's needs were to be met in the event of an emergency, for example if the service experienced a utility failure or a flood.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- The area manager informed us they met with the provider and others as part of the governance of the service. There was no evidence at the service as to the outcome of these meetings or any agreed actions.
- We requested minutes of meetings between the area manager and those representing the provider to be forwarded to the CQC following our site visit, to evidence how information gathered by the area manager was shared and used by the provider to plan the future development of the service. We did not receive the information. Therefore, we cannot be confident that governance arrangements are effective to ensure the continued development of the service. For example, staff training.
- The area manager regularly visited the service both announced and unannounced to support the

registered manager.
● A system of auditing was in place covering topics related to the environment, staff records and people's care to monitor the service so improvements could be made, these were reviewed by the registered manager and area manager.
●The day to day running of the service was well organised, staff were clear about their collective and individual duties and worked together to provide care. A person told us, "It seems that they [staff] have a good working relationship here."
● Meetings involving different members of the staff team took place, this included staff meetings, nutrition and hydration meetings. This enabled staff to share information about key aspects of people's care. Meetings were linked to surveys carried out in key areas, which included meal quality.
● The service had received compliments about the care provided in the form of thank you cards and letters, which were displayed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● Meetings were organised for family members; however, these were not well attended. Family members had mixed knowledge of the meetings. One family member said, "There is a relative's meeting next week I think."
● People's views and that of family members were sought through the surveys and comments gathered were used to make changes. Surveys in some instances targeted specific topics, for example meals. A survey in March 2019 on the topic of meals identified a high satisfaction with the meals provided. Suggestions for the menu were recorded. We spoke with the chef who was able to evidence how people's suggestions had been incorporated into the menu.
● Staff views were sought through surveys, the most recent had taken place in March 2019. The staff survey found that most staff felt supported by the registered manager.
●The staff survey had identified additional training on the management of behaviour that challenges was requested by staff as previous training had not been of benefit to them. The registered manager advised us that the provider was sourcing additional training.

Continuous learning and improving care; Working in partnership with others:
● The registered manager spoke of their commitment to continually improving the quality of care people received and the continued development of staff through improved learning opportunities.
● Good practice guidance was available for staff to read, which included information on the mental capacity act and the gold standards framework.
● A range of health care professionals work collaboratively with staff of the service to achieve good outcomes for people's care. Health care professionals we spoke with told us staff were responsive to their views and had worked to build positive working relationships which had had a positive impact on people's lives.
● Information submitted by the registered manager in the Provider Information Return identified future plans for the development of the service which included closer links with the local community to benefit people using the service.

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 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to meet the needs of people. Staff did not undertake effective training to enable them to support people living with dementia and those whose behaviour was challenging.