Guild Care

Caer Gwent

Inspection report

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Date of inspection visit:
14 January 2020
15 January 2020

Date of publication:
24 February 2020

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:
Caer Gwent provides accommodation, personal care and nursing care for up to 60 older people. At the time of our visit 56 people were living at the service. Seven of those people were living at the service on short or long-term respite.

Accommodation was provided over two floors in an adapted building. Rooms were in four separate units, but all communal areas were shared across each unit. There were communal areas including lounges, dining rooms, a restaurant, a piano room used for entertaining and socialising, and an adapted garden. People were able to move freely around the home and had access to three lifts.

People's experience of the service:
People gave us mixed feedback about whether staff were always caring or kind. This feedback was shared with the provider. During our visit, we observed positive interactions between staff and people. We observed people were treated with respect. We observed people were happy and relaxed in the presence of staff.

From people's feedback and in their responses to a recent resident survey, there was mixed feedback about whether staff were deployed appropriately to meet people's needs and to give them support when they needed. For example, we received some feedback from people about waiting for call bells to be responded to.

Quality assurance reviews to measure and monitor the standard of the service and drive improvement were not always effective.

At this inspection, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004 regarding Good governance.

A relative told us, "We have been absolutely delighted with the care [Person] receives and incredibly grateful to the staff for their outstanding compassion, hard work and commitment." A visiting friend told us, "It's more like a hotel than a home, it has everything [Person] needs."

People and relatives knew how to make a complaint. Formal complaints were investigated and acted upon. People gave us mixed feedback about whether they felt confident that their feedback, such as a informal complaints or concerns, was listened to and acted upon.

People had enough to eat and drink and had choices in what they ate and drank. There was mixed feedback, however, about people always getting food that was consistent with the choice they had made or with what they had told staff they disliked. Staff accommodated any specific dietary requirements such as allergies.

Staff were knowledgeable and experienced to deliver care including nursing. People were supported by staff to have maximum choice and to make decisions about their care.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

People were protected from infection by staff that kept the premises clean and used appropriate protective equipment when needed. Medicines were managed safely and in accordance with current regulations and guidance.

Recruitment processes continued to be robust. Staff knew how to keep people safe in an emergency.

People took part in structured activities. People were supported to pursue their own hobbies and there was time for activities and care staff and volunteers to spend one to one time with people.

Visitors were made welcome and interactions between staff and visitors were warm and friendly. Family and friends were able to visit freely without restriction.

Care plans described people's needs and preferences and guided staff about people's needs and how to meet them. Health and social care were accessible for people.

Staff told us they felt supported, records showed they had regular supervision and annual appraisals.

The overall rating for the service was Requires Improvement. This is based on the findings at this inspection. More information is in the 'Detailed Findings' below.

Rating at the last inspection: The last rating for this service was Good (published 25 April 2017).

Why we inspected: This was a planned comprehensive inspection that was scheduled to take place in line with Care Quality Commission (CQC) scheduling guidelines for adult social care services.

Follow up: We will review the service in line with our methodology for 'Requires Improvement' services. If any concerning information is received, we may inspect sooner.

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

Caer Gwent

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was carried out by two inspectors on 14 January 2020 and by one inspector for a second day on 15 January 2020.

Service and service type:
At the time of our visit, 56 people were living at the service. People who lived at the home had varied needs associated with old age and frailty and specific needs such as mobility, Parkinson's, dementia, dysphasia following stroke and diabetes. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The day to day running of the service was being managed by two deputy managers while waiting for a new manager to start who had been successfully recruited. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The first day of the inspection was unannounced, this means that people and staff did not know we were visiting and the second day of the inspection was announced.

What we did:

Before the inspection: We reviewed information available to us about this service. We checked the information that we held about the service and the service provider. This included previous inspection

reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law.

The provider was not asked by the CQC to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with nine people, a visiting friend and a visiting professional.

We spoke with ten members of staff, including care staff, nursing staff, managerial staff, kitchen staff and the health and well-being co-ordinator.

We reviewed a range of records such as four care plans, three medication records and one daily progress notes. We looked at staff records in relation to recruitment and training. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

After the inspection
We received feedback from a relative and two health professionals by email who gave us permission to quote them in this report. We received further information from the provider about staffing, supervisions and training.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Requires improvement: This meant 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.

Staffing and recruitment

● People gave us mixed feedback about whether there were enough staff to meet their needs. Some people we spoke to did not need to use a call bell, those who did need to use their call bell gave us the following mixed feedback: "Normally they come quite quickly", and "Staffing is not just numbers, it is whether they work as a team". Two people told us that staff had not responded to their call bell, so they had resorted to calling the reception desk. One person had made a formal complaint in November 2019 where they had waited over an hour for a response. A person said, "They leave me on the commode while they see somebody else. They might be 35 minutes. They take a long time, or they come in and switch it off and they don't come back."

● In recent relative and people surveys there was negative feedback about response times to call bells and about staffing levels at night time. As examples survey responses said, "Bells often take a long time to be answered."; "Not enough staff at night."; "Time to answer my call bell could be better".

● Managerial staff who managed the day to day running of the service did not have access to the call bell records and were not able to carry out audits to check call bell responses beyond observing response times during the day on week days. We recommend that where managerial staff are given responsibility for the day to day running of the service they are given access to the systems needed to have oversight of the response times to call bells.

● Following the inspection, the provider sent us call bell records as these were not available to us during our visit. These showed that some people, when they pressed their call bell for assistance, were not always responded to in a reasonable timeframe. This was an area of improvement.

● Staff also gave us mixed feedback about whether there were always enough staff to meet people's needs. A care assistant said, "Especially at night there is a need for more staff, could be managed better." Another care assistant said, "I think there's enough staff, we have a lovely strong team, weekend is a bit more of a challenge but in the last year we've made changes to improve." A third care assistant said, "Sometimes it's rushed but we try to answer bells the best we can. We have flexibility so that once you finish your section you can go over to offer help as and where it's needed." A nurse told us, "I do think there's enough staff. In the past staff have been fixed on where they're working whereas now staff are being more flexible." Another nurse told us, "Staffing depends, sometimes staff blend beautifully and sometimes we have to prompt and encourage staff to communicate if things are falling behind or getting delayed, that's why we have the care supervisors, we can talk to them."

● We told the provider about this mixed feedback. They told us that staffing levels were assessed based on people's support needs and showed us records relating to this after the inspection. After the inspection, the provider told us that they were undertaking further work to improve call bell response times. Records such as rotas confirmed that staffing was at the level determined by the provider in their assessments and the

provider told us that unplanned absences were covered by bank and agency staff.
● Robust recruitment systems ensured that new staff were safe to work in a social care setting. Staff files showed that checks had been made with the Disclosure and Barring Service which considered the person's character to provide care. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC) before and during their employment.

Systems and processes to safeguard people from the risk of abuse
● We observed that people were comfortable in the presence of staff however people gave us mixed feedback about whether staff were always kind and caring, we have written about this further in the 'Caring' section of this report.
● Staff had completed training in safeguarding and knew how to recognise the signs of potential abuse. Staff knew what actions to take if they had concerns and records confirmed this.

Assessing risk, safety monitoring and management
● Staff knew how to keep people safe in the event of an emergency such as a fire. Staff were trained in fire safety and in using equipment to keep people safe.
● People's risks had been identified and assessed. People had a range of risk assessments including eating or swallowing, falls and mobility. Staff understood assessed risks for people and knew how to support people to avoid any risks identified.
● Staff made a safe environment for people and had access to equipment or aids they needed to stay safe. A relative told us, "As her care needs have increased over the recent year, they have provided a special air-filled mattress, safety sides for the bed, alarm mat, hoist, extra pillows/cosy fleeces and even a wonderful wheelie relaxer chair so [Person] can move safely and comfortably around the home. The individual alarm [Person] wears is lightweight and easy to access. I have always felt [Person] is in safe hands at Caer Gwent."

Using medicines safely
● People told us they received the help they needed with their medicines. Senior care staff and nurses were trained in the administration of medicines and their competency was checked annually. Medicine audits and stock checks were carried out weekly and monthly by staff.
● Medicines were managed safely. Records showed that medicines were ordered, stored, administered and disposed of as required, including medicines that needed special storage arrangements. Where people had as and when needed (PRN) medicine staff were guided by individual PRN protocols. Where people had prescribed topical creams, this was recorded.
● Staff had implemented laminated signs to be with people's Medication Administration Records (MAR) as a prompt to staff about each person's PRN and as a prompt if a person was currently on antibiotics, a senior carer told us this worked well.
● Where people had homely remedies, this was recorded. A senior carer told us, "Any homely remedies that are kept in a person's room that family bring in is recorded, of course we assess if that person is safe to do this or have those in their room, if the person has capacity and are safe they have the right to have those things in their room."

Preventing and controlling infection
● The home was clean and well presented. A person said, "They do cleaning really well, they look after the rooms really well." A team of housekeeping staff worked throughout the week.
● Staff were trained in infection control and we observed staff using appropriate personal protection equipment (PPE) and washing their hands. A relative said, "Staff are very professional, using protective aprons and gloves where appropriate."

Learning lessons when things go wrong

● Incidents and accidents were recorded and monitored. Actions taken in the short and long term were also recorded. Records showed that help from health and social care professionals had been sought immediately where needed. Managerial staff benefitted from colleagues in their head office assessing incidents and accidents and reporting trends analysis to inform them of measures to prevent future incidents from reoccurring.

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 available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● People told us they enjoyed the food, despite this some people told us they did not always get food and drink that reflected their preferences or what they had chosen to have for that meal. Staff felt that it gave people control to ask them what they would like and to not assume what a person wants however people gave mixed feedback that they found it frustrating to be asked every day. A person said, "I get the right selection (what they chose) depending on who is on.", the same person said, "I told kitchen staff I don't like certain food items, one day I had both served to me." Another person told us, "When it is a strawberry yoghurt the chef will just give me a few strawberries, he knows I don't like yoghurt." Another person said, "The food is good, good choice. Staff come every evening and ask your choices for the next day." We told the provider about this and they agreed to review how preferences are recorded and reflected in food and drink given to people. Ensuring that people receive food and drink that reflected their choices and preferences was an area of improvement.

● People had varied needs for meal arrangements and support. For example, one person was independent, they said, "I have a fridge and I get food deliveries. I mix and match. With the new chef we now have salad on the menu and kitchen staff are helpful to me."

● Staff knew of people's allergies and specific dietary needs and kitchen staff accommodated these needs. The Chef told us that they learn about people's allergies and needs such as food-controlled diabetes or fortified diets for when people are losing weight.

● During our visit we observed that people had sufficient to eat and drink and had support to receive their meal as and when needed. People had access to adapted cutlery and/or cups and plate guards. A relative told us, "They are discreet helping her to choose her preferred food/drink, when she is unable to tell them."

● Where people were assessed by a Speech and Language Therapist (SALT), the guidance from this assessment was recorded, and all staff knew each person's needs such as the need for soft and moist food. Staff knew if people need thickeners and staff followed IDDSI (International Dysphasia Diet Standardisation Initiative) thickener levels and guidance.

Staff support: induction, training, skills and experience

● People and relatives told us that staff were knowledgeable to meet their needs. A relative told us, "They are competent and confident using slings and hoists. They work well as a team, making sure [Person] is safe and comfortable."

● Staff told us they received training considered mandatory by the provider. Staff were encouraged to study for vocational qualifications in health and social care. New staff followed the Care Certificate, a work-based, vocational qualification for staff who had no previous experience in the care sector. Records showed that

new staff had additional support within their induction period such as observations and 'buddy shifts' where they were partnered with senior established staff.
● Staff had access to training that was specific to people's needs such as additional training in communication, dementia and pressure care. A nurse said, "Training is really good. We've had training from the hospital avoidance matrons, speech and language team and continence advisory service." A health professional told us, "Staff know what they are doing and are informed about individual patients needs and concerns. I have run several Parkinson's disease teaching sessions in the home."
● Since the last inspection the provider improved how frequently supervision was held for staff. Staff told us they had frequent supervision, worked well as a team and felt well supported by managers. They each had an annual appraisal. A nurse told us, "I have supervisions from the clinical lead, they're good at doing observations and adding that to supervision so we have reflective discussions. I feel supported." Another nurse said, "The clinical lead makes themselves available for advice morning, noon and night, I feel very supported, likewise with nursing colleagues I feel supported, they're fantastic. I have regular supervision, but I can always have a one to one if I need".

Staff working with other agencies to provide consistent, effective, timely care
● People were supported by having access to a wide range of health and social care professionals, for example GP, community mental health team and dietitian. Records, and external professionals we spoke to, confirmed this. Staff told us that people who were registered with a local GP benefited from a weekly nurse practitioner round.
● A health professional gave positive feedback about staff referring to health professionals when appropriate, they told us, "Staff have identified risks with patients to me and requested appropriate review. When I am visiting, staff always get the nurse on duty and I can also speak to carers as needed. The deputy manager contacts me appropriately when there is an issue with a patient that is related to my specialism."
● Each person had an emergency hospital plan stored with their MAR. Staff told us this was helpful because it would be taken if a person needed to be admitted to hospital and made sure there was information for hospital staff to understand the person's needs and their preferences.

Adapting service, design, decoration to meet people's needs
● People had access to equipment for their mobility or pressure care needs. People had access to a range of mobility aids. A relative confirmed that they felt their relative was kept safe by adaptations in the home, they told us, "Doors are alarmed where appropriate. The front door is secure. There are no trip hazards, the corridors are wide enough for safe passage. The gardens are peaceful and beautiful without steps or hazards."
● The building had serviced lifts as well as stairs. Premises were managed safely. Internal environmental checks were completed.
● People's rooms had personal items. All rooms had en-suite bathrooms with shower with the exception of three rooms that shared a bathroom. People also had access to adapted bathrooms with baths to use if they wished, including a jacuzzi spa bath.

Supporting people to live healthier lives, access healthcare services and support
● People told us they received the care and treatment they needed. A person said, "If I am poorly they help. If I ask for help I get it." Another person told us, "Now we have our own vehicle that I can get in to and I use that for health appointments." A third person said, "The Nurses are excellent. The doctor came Sunday after I had a fall, they (staff) came quickly, quite a few of them." Records showed that staff liaised with other agencies and health and social care professionals such as the GP or speech and language therapist.
● Relatives gave positive feedback about how nursing staff managed their relatives' nursing needs. A relative said, "Staff always let me know if there is a problem…The Nurses are accessible when I visit, and I am able to

ask for up to date medical news if I need it. [Person] has been extremely poorly on at least three occasions, requiring paramedics and hospital admittance. Staff were fast to call for medical intervention and let me know immediately. When I was unable to get to the hospital immediately, they sent a member of staff until I could meet them there, ensuring [Person] had a familiar face with her."

●People's care plans reflected any needs or conditions such as diabetes and choking risks. Oral care needs for teeth or dentures and support people needed with this aspect of their care were described in care planning.

● A visiting private hearing audiologist told us, "I've had quite a few visits here, family or staff will call me in. Everyone is friendly, the home is welcoming and clean. People's rooms are nice and clean. Staff are always really lovely."

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

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 when this is in their best interests and legally authorised under the MCA.

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.

● Managerial staff liaised with the DoLS teams for relevant local authorities and sought advice. Any restrictions on people's liberty had been authorised, managerial staff had oversight of this and worked with the local authority.

● People's capacity had been assessed to make particular decisions in relation to their care and support. Where people were assessed to not have capacity to make particular decisions, best interest meetings were held involving staff that knew the person well, the appropriate relative and relevant professionals. These discussed options to find the least restrictive and safest option for the person.

● Staff understood best interest decision making processes and involved appropriate stakeholders such as external health and social care professionals however these were not consistently formally recorded beyond daily notes. We talked to the provider about this and they agreed this was an area of improvement in recording.

● Records showed that each person's care was reviewed periodically or when needed with the person where possible, appropriate relatives or friends and relevant professionals. Where a person lacked capacity around a decision staff involved the person's representative such as a relative with Lasting Power of Attorney for health and welfare. Examples of this were seen for decisions for example for bed rails, covert medicines or the use of a sensor mat.

● Staff understood the principles of the MCA and our observations confirmed this. A nurse told us, "I ask people how they would like certain things. I give them a choice, we let people make their own decisions and

respect that people have the right to take positive risks and make decisions, we can only advise and let the person weigh up the pros and cons."

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.

At the last inspection this key question was rated as Good. At this inspection, this key question has deteriorated to Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We received mixed feedback from people about whether staff were always kind and caring. We observed friendly and caring interactions between staff and people, but people said that there were a few staff that were not caring, we told the provider about this and they took immediate action with our support. A safeguarding was raised due to feedback and the provider took immediate action such as speaking to the local safeguarding team, starting an internal investigation and suspending a member of staff until an investigation had been completed. Ensuring that staff cared for all people and treated all people with kindness and respect was an area of improvement.
- A person said, "Most of the staff are friendly and patient but other staff, usually when busy, can be a bit short." Another person said, "Care staff will say 'you're not on my section'. It's not as nice as it used to be (here). (I) Used to be really happy when I first came but not so happy now." A third person said, "Some of the carers are wonderful but some are just here for the job and they talk about people in my room, well I've got to go and do 'so and so'. Most are good, but you get the one or two that are not nice."
- In a feedback form recently completed a respondent wrote, "Staff at night inadequate, commode was not put out for relative and staff member shouted. Overall care at day is good, and staff with careless attitude." Another feedback form read, "Night staff periodically unhelpful and difficult."
- Some examples of positive feedback from people and positive feedback in survey responses were; A person said, "I'm quite happy here. The staff are excellent. They're friendly, they are nice, and they are kind." Another person said, "The carers are very helpful, they do what they can to help you." A person wrote in a feedback form, "care and support is top class, understanding is excellent." Another feedback form read, "(Staff are) mostly caring, polite and helpful."
- A relative said, "All types of staff very often go beyond the call of duty. I have absolutely no hesitation in recommending Caer Gwent. It gives me huge peace of mind that [Person] is happy." A relative's feedback form read, "I am extremely happy with the care and kindness we have received since [Person] came here, carers are great."
- People were supported to pursue any religious, belief or spiritual preference. Church services and seasonal celebrations were arranged at the home and people were supported to access places of worship of their choice.

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

- Records showed that people and appropriate relatives were involved in informing the person's care plan and in making decisions about their care. Relatives we spoke to confirmed that they were involved in decisions when appropriate. A relative told us, "They ensure her views and preferences are paramount. They

respect her dignity."

● We observed that people were supported to make choices and decisions. A care assistant told us, "You learn from spending time with a person what they like and don't like but at the same time you never make an assumption, I always offer a person choice's, they have the right to change their mind or to decide from one day to the next."

● People were encouraged to write their own care plans, for example two people had written their own care plans with staff typing it out for them, managerial staff told us, "That way their can add their thoughts, specific wishes and preferences and they feel in control and more involved." A person told us, "My care plan is unique here. I write my own and it expresses things in a very forthright manner".

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity were upheld, our observations confirmed this. A care assistant told us, "When I'm giving person care, I encourage people to wash what they can, and I ask if they need help because they have the right to say no. I ask their preferences like deodorant or perfume and talk to them about what clothes they would like me to get for them."

● People were supported to present themselves in accordance with their grooming or clothing preferences and these preferences were recorded in their care plan. People had access to a hair salon at the home, beauty therapists visited twice a week and hairdressers visited five times a week. A relative told us, "Staff know [Person] very well, including her likes and dislikes. They know she loves to wear perfume and lipstick. They make sure she wears her favourite waistcoat and is snuggled up with throws." Where people had a preference of the gender of carer this was respected and accounted for in the staffing.

● People's confidential information was kept secure by staff. Staff had locked cabinets and offices where they could keep information safe. People also kept information related to their care planning safely in their rooms.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question remained the same.

Good: This meant people's needs were met through good organisation and delivery.

Improving care quality in response to complaints or concerns
● Formal complaint records showed that formal complaints were investigated, acted on and followed up. Records showed that actions were recorded, and that staff took appropriate action such as apologising or raising learning at staff meetings. When there was a complaint involving a staff member from an agency this was reported and shared with the agency. We have written more about informal complaints and concerns in the Well-led section of this report.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences;
● People were supported by staff that knew them well including their needs, preferences and interests.
● Care plans were person centred, they included information about the person's background, their current needs, their likes and dislikes.
● People's needs were assessed before coming to live at the home. These assessments included health and emotional wellbeing needs and was inclusive of protected characteristics such as disability or religious needs. Since the last inspection staff had encouraged people or their relatives to complete information about their personal, social and employment history in a book called 'Our life'.

Supporting people to develop and maintain relationships to avoid social isolation
● Staff supported people to avoid social isolation, for example where a person chose to stay in their room by choice or because they were cared for in bed, activities and care staff or volunteers had time to visit people daily for a chat or to do an activity. A person who preferred to stay in their room told us, "[Volunteer] or [volunteer] will come to visit me in my room and I'll go out to lunch with [Staff member]. I like to read so staff bring me magazines and books." A volunteer told us, "Activities coordinator is good at saying who needs more TLC or who is staying in their rooms, I'll visit them, it is nice to have a chat and talk about the news or whatever they want."
● People were supported to maintain relationships that were important to them and we observed that family and friends were welcomed to visit without restriction.

Supporting people to follow interests and to take part in activities that are socially and culturally relevant to them
● A structured activities programme was available to people including external entertainers, word games nursery school visits and outings to a local pub, garden centre or restaurant.
● Relatives confirmed that a structured activities programme was available that their loved ones enjoyed. A

relative told us, "Activities arranged for the residents are many, [Person] particularly loves the ballroom dancing, where she is gently danced with whilst sitting in her wheelchair. She also loves the visits from animals… and the visits from nursery schools are a great hit, plus all the theme days".

● People enjoyed the visiting animals and pets as therapy visits. The home had a pet parrot which we observed people and visitors interacting with. People could bring pets when they moved in, for example some people had their pet budgies in their rooms.

● People were supported to pursue individual interests, passions and hobbies. One person had an interest in football and staff accompanied him to a weekly 'sporting memories' get-together at a local football club. Three people had participated in an exhibition at a local museum, a person enjoyed knitting, a person did poetry readings at the home, another person played the piano for people and another person enjoyed coin collecting.

Meeting people's communication needs

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

● People's communication needs were assessed and met in a way that met the criteria of the standard. This included recording people's communication needs in their care plans and staff reflecting this in how they cared for people.

● One person used a communication book due to dysphasia following a stroke. A senior carer showed us the person's communication plan The senior carer told us, "[Person] has glasses but chooses not to use them, [Person] has a communication booklet that we try to use but [Person] does not use this often due to eyesight. For staff though, especially new staff that are getting to know [Person] it's helpful." We reviewed the person's communication plan which explained "When I do this", "We think it means" and "We should".

● A care assistant told us that a person does not use their hearing aids until they have had a shower in the morning, they told us, "I use sign and speak at the same time while we're supporting her to wash in the morning so that she can express what she wants or doesn't want."

● People were supported to maintain contact with family and friends by telephone or their own devices. People had telephones in their rooms that we observed people using. Where people did not have their own laptop, computer or device where they could call or skype loved ones they had access to a computer lounge in the home.

End of life care and support

● Provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death. People were supported to receive care and treatment up to the end of their lives in the home where staff could continue to support them. Nursing staff were trained in end of life care through a local hospice and were trained in using specific palliative care equipment, such as syringe drivers.

● At the time of the inspection, no one was receiving end of life care however three people had been identified as approaching end of life by a health professional and due to this staff had access to anticipatory prescribed end of life medicines if needed.

● Where people had a do not attempt cardiopulmonary resuscitation (DNACPR) or an advanced care plan, this was recorded. Where people agreed to discuss their preferences and choices in relation to end of life care, this was recorded.

● We saw compliment records where relatives or friends had thanked staff for their care for a loved one who had passed away, we saw positive compliments such as, "Thank you for making her last days as dignified and peaceful as possible" and "You were so kind and understanding, you went the extra mile for her, thank you."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they had taken part in 'resident meetings' however we received mixed feedback about whether this meant they felt listened to or whether improvements happened if they raised concerns. Minutes were made available to us of these meetings after our visit. Where people had made requests or raised concerns, that were not formal complaints, people gave us mixed feedback about whether this resulted in changes or improvements. One person said, "Not really useful, I said something for over a year, but nothing ever happens. It's a waste of time".
- People gave us mixed feedback about whether they felt confident that their feedback, such as an informal complaint or concern, was listened to and acted upon. We told the provider about this and they told us that they will review this. Any improvements made will be reviewed when we next inspect.
- People and relatives were given the opportunity to give their views on the service through an annual survey. 2019 surveys had recently been collected and due to this had not yet been analysed through the provider's head office.
- Records made available after the inspection showed that resident and relative meetings were held monthly and quarterly cheese and wine evenings were held as a sociable event for relatives.
- Team meetings, such as general all staff meetings and meetings for role groups such as care staff or nursing staff were held regularly, records confirmed this. Staff were well established and told us they enjoyed their work. Staff consistently told us they felt supported by colleagues and managerial staff. A nurse told us, "Everyone gets on really well, we have regular meetings for staff. Anything addressed in staff meetings is generally acted upon."
- Staff told us they felt valued. Staff and volunteers received a newsletter that celebrated achievements.

Continuous learning and improving care

- Governance systems were not always effective. The provider had not identified that people did not feel listened to or that choices and preferences were not always reflected in meals. Records showed that quality assurance systems monitored the quality of service being delivered and the running of the service in certain aspects of the service such as medicine and health and safety, where these identified areas for improvement these were documented in an action plan. Records were made available to us after the inspection demonstrating that the provider was aware of the issues with call bell responses and improvements needed in how staff consistently interacted with people and had recorded these in an action plan. Managerial staff were supported by the provider's quality assurance team who for example carried out mock inspections.

The lack of effective governance systems to monitor the quality of the service and to listen to feedback from people and make changes and improvements was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2004 regarding Good governance.

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

● Staff demonstrated pride in their roles and valued making a welcoming atmosphere for people and visitors. A care assistant said, "It's really nice working here, I absolutely love it." A nurse told us, "I really like it here. Residents here are lovely, I appreciate having conversations with them." A volunteer told us, "It is like an enormous family, full of concern and care and love. Care staff seem to be very good. If I raise something it does get sorted out." We observed a friendly and welcoming atmosphere.

● During our visit a person told us they were writing a newsletter for people living at the home with the activities coordinator, we will review this when we next inspect.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● All managerial staff understood the regulatory requirements that needed to be met to achieve compliance. For example, notifications required to send to CQC by law had been completed.

● At the time of the inspection a registered manager was not in post. Despite this, staff consistently said that despite a change in management there had been a smooth transition and no negative impact due to deputy manager cover, provider support and swift recruitment of a new manager. A care assistant said, "Everyone's got on with their day job, we're a good team that pulls together." A nurse said, "The change in managers hasn't had any adverse impact." People also gave this feedback, a person told us, "I've not noticed any difference without the previous manager."

Working in partnership with others

● Records showed that staff liaised with external professionals to support people to achieve good outcomes. We received positive feedback from external professionals, for example a health professional told us, "I don't hear anything other than care, compassion and empathy coming from the wonderful management and care staff while on my rounds."

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 17 HSCA RA Regulations 2014 Good governance There was a lack of effective governance systems to monitor the quality of the service and to listen to feedback from people.