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Southcrest Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 12 November 2018. The first day of our inspection visit was unannounced.

Southcrest Nursing 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.

The service is registered to provide accommodation with nursing care for up to 40 older people some of whom are living with dementia. The accommodation is split across three floors within one large adapted building. At the time of our inspection, there were 28 people living at the home.

There was a registered manager in post who was present during our inspection. 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.

The provider needed to improve infection control practices at the service to better protect people from the risk of infections. People shared hoist slings and these were not always cleaned in between using them for different people. Plans to minimise the known risks to individuals were not always sufficiently clear, and the security of the home's front door had not been fully risk assessed. Written guidance on the use of people's 'as required' (PRN) medicines was not always clear or up to date. Staff had not been consistently inducted in line with the requirements of the Care Certificate and did not benefit from consistent supervision and appraisal with a senior colleague or member of the management team.

Further work was needed to create a more dementia-friendly environment within the home. Staff did not always protect people's personal information, by ensuring this was accessible by authorised persons only. People and their relatives expressed mixed views on the support people had to participate in stimulating and enjoyable activities, and pursue their interests. The information recorded in people's care plans was not always accurate or sufficiently personalised, lacking details of their known wishes and preferences. The management team and nurses lacked insight into the Accessible Information Standard. Staff needed to adopt a more consistent approach to identifying people's preferences and choices for their end-of-life care, through discussion with them and their relatives. The provider had failed to notify us of a serious injury and a safeguarding concern involving people who lived at the home. The provider needed to improve the overall effectiveness of their quality assurance activities.

The provider undertook regular checks on the condition of the premises and care equipment in use to promote people's safety. Staffing levels and staff deployment were monitored and adjusted, on an ongoing basis, in line with people's current care and support needs. Staff recognised the need to remain alert to and

immediately report any form of abuse involving the people who lived at the home. Any changes in the risks to people were communicated effectively across the staff team. Staff recorded and reported any accidents, incidents or unexplained injuries involving people living at the home. The management team reviewed these reports to identify learning and prevent things from happening again. The provider completed pre-employment checks on prospective staff to ensure they were safe to work with people.

People's individual needs and requirements were assessed before they began using the service, to ensure the provider could meet these effectively. Any risks or complex needs associated with people's eating and drinking were assessed and plans put in place to manage these. Staff monitored any changes in people's general health and helped them access community healthcare services. The management team recognised people's rights under the Mental Capacity Act and sought to promote these.

Staff treated people with kindness and compassion, and were attentive to their needs and requests. The management team had an 'open door' policy, and encouraged people and their relatives to share their views on the service.

Staff had guidance on how to promote effective communication with individuals. The management team promoted a positive and inclusive culture within the service, which valued people's individual differences. People and their relatives understood how to raise any concerns or complaints with the provider, and felt comfortable doing so.

The registered manager spoke about their work with clear commitment and took steps to keep themselves up to date with best practice guidelines and legislative changes. People and their relatives knew who the registered manager was, and felt they were approachable. Staff felt they had the management support and direction they needed to succeed in their roles, and felt their efforts were valued by the management team. The community health and social professionals we spoke with described a positive working relationship with staff and management. The provider took steps to involve people, their relatives and staff in the service provided.

You can see what action we have told the provider to take at the back of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Infection control practices did not ensure people were protected from the risks of infection.

The plans for minimising the risks to individuals were not always clear.

Staff had received training on, and understood, their individual responsibilities to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always inducted in line with the requirements of the Care Certificate.

Staff did not benefit from consistent supervision and appraisal.

People had the support they needed to eat and drink comfortably and safely.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always protect people's right to privacy and confidentiality.

Staff adopted a kind and compassionate approach to their work.

People and their relatives were encouraged to express their views on the service provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The information recorded in people's care plans was not always accurate or sufficiently personalised.

People and their relatives expressed mixed views on the support people had to take part in recreational activities and pursue their interests.

People and their relatives were clear how to complain to the provider, and felt comfortable doing so.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The provider had failed to notify us an incident in line with their regulatory requirements.

The provider's quality assurance activities did not always identify areas to improve the service and protect people from risk.

Staff felt valued and well-supported by an approachable management team.

Southcrest Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection checked whether the provider 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.

The inspection was prompted in part by information shared with CQC which indicated potential concerns about staff moving and handling practices, the management of people's health needs, the administration of people's medicines and the overall treatment of people living at the home. These issues are under investigation by the local authority and, as a result, this inspection did not examine the specific allegations made against staff and management. However, the inspection did examine the potential areas of risk indicated in the information we received.

The inspection took place on 9 and 12 November 2018. The first day of the inspection visit was unannounced. The inspection team consisted of two inspectors, an Expert by Experience and a specialist advisor who is a nurse specialist. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience and specialist advisor were only present for the first day of the inspection visit.

Before the inspection visits, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, local clinical commissioning group and Healthwatch for their views on the service.

During our inspection, we spoke with five people who used the service, eight relatives, three friends of people living at the home and four community health and social care professionals. We also spoke with the registered manager, deputy manager, two nurses, three senior care staff, four care staff, the cook, an activities coordinator, the office administrator and the maintenance worker.

We looked at a range of documentation, including 14 people's care and assessment records, medicines records, incident and accident reports, four staff recruitment records and staff training records. We also

looked at complaints records, selected policies, certification related to the safety of the premises and records associated with the provider's quality assurance.

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.

Requires Improvement

Is the service safe?

Our findings

At the time of our last comprehensive inspection in April 2018, the 'Safe' key question was rated as 'Requires Improvement'. At this inspection, we found further improvement in the service was still needed. The rating remains 'Requires improvement'.

At our last inspection, we found staff did not always protect people from the risk of cross-infection through, amongst other things, making appropriate use of the personal protective equipment provided (PPE). PPE includes the disposable gloves and aprons made available for staff use. At this inspection, we found the provider still needed to improve infection control practices at the home. During our inspection visits, we found the home's environment and the specialist care equipment in use to be clean and hygienic. A relative told us, "I have no concerns with the cleanliness of my relative or this place." Domestic staff supported care staff in ensuring standards of hygiene and cleanliness were consistently maintained. Staff had access to and made consistent use of appropriate personal protective equipment. Suitable hand-washing facilities and hand sanitiser dispensers were located at appropriate points throughout the home.

However, staff informed us hoist slings, which were shared amongst the people who lived at the home, were not always cleaned in between using them for different people. This does not reflect good infection control practice. Hoist slings are a potential source of cross-infection, as they are absorbent fabric products which come in direct contact with people's bodies. We discussed this issue with the registered manager. They were not aware staff were sharing hoist slings between people and informed us there were sufficient slings available on site to avoid this. Following our inspection visits, the registered manager confirmed hoist slings were now used for a named person only, and were appropriately cleaned and laundered to protect people from the risk of infections.

The provider carried out regular checks on the safety and condition of the premises and care equipment in use to keep people safe. This included in-house and external testing of the home's fire alarm system, and the servicing of wheelchairs and hoists at regular intervals. The management team and nurses also assessed and kept under review the risks associated with people's individual care and support needs, using recognised assessment tools. These risk assessments considered a range of factors, including people's vulnerability to falls and pressure sores and any risks or complex needs associated with their eating or drinking.

Plans had been developed and recorded in people's care records to minimise the identified risks to individuals and keep them safe. However, we found these plans were not always sufficiently clear. One person had been known, on occasions, to attempt to leave the home unaccompanied and had previously gone missing for a period of a few minutes in June 2018. Their risk assessment did not clarify how staff were to reduce the risk of them leaving the home unnoticed, referring only to the need to lock the front door 'most of the time'. We also found the procedures for securing the home's front door had not been fully risk assessed, to prevent unauthorised access to the service. A member of staff told us the front door had, at times, been left open when the building was particularly hot. On this subject, a healthcare professional told us, "The front door isn't always locked. Some residents have dementia, and that could be an issue." We

discussed these issues with the registered manager. They assured us robust risk assessments would be completed, without delay, in relation to the risk of the individual in question leaving the home unnoticed and the overall security of the front door. We will check this at our next inspection.

The provider had systems and procedures in place designed to ensure people received their medicines safely and as prescribed. People's medicines were handled and administered by nurses, who underwent periodic medicines training and annual competency checks. People's medicines were stored securely in a locked medicines cupboard and in the home's medication trolleys located on each floor. The temperature of the medicines room and medicines fridge were checked daily to ensure these stayed within the recommended range. The nurses recorded the medicines they administered on people's individual medication administration records (MARs).

However, the guidance on the use of people's 'as required' (PRN) medicines was not always clear or up to date. One person was prescribed a medicine for the treatment of anxiety and insomnia. Their 'PRN protocol' referred to the incorrect dosage of this medicine and did not clarify the specific circumstances in which it should be used. Although this medicine had been administered on a consistent nightly basis, there was no reference to its use in the individual's care plans and it was unclear how this had been monitored. We discussed these issues with the registered manager who assured us the individual's GP was aware this PRN medicine was being used on a regular basis, however they acknowledged this had not been clearly recorded in their care records. They told us they would ensure there was clear and up-to-date guidance on, and consistent monitoring of, the use of people's PRN medicines going forward. We will check this at our next inspection.

At our last inspection, people's relatives expressed mixed views on the adequacy of the home's staffing arrangements. At this inspection, most people and their relatives were satisfied with the staffing levels maintained at the home. One relative told us, "I have never felt there was not enough staff to support people." However, one person voiced a concern about the slow staff response to their call bell at night. A relative also felt their loved one had to wait too long for help to use the toilet at times. They told us, "Sometimes [person] has to wait ages for assistance to go to the toilet. They sit in the lounge on their own and they have no means of calling for assistance if there are no carers around. They [staff] seem to be away for quite long periods sometimes." Staff felt the staffing levels maintained at the home enabled them to safely meet people's individual needs. One staff member told us, "You are not rushing around. It's not about doing the job in a certain time; it's a relaxing home." However, two staff members felt staffing levels on the home's middle floor could be improved to enable them to better meet people's conflicting needs and requests.

We discussed the issues raised in relation to staffing at the home with the registered manager. They assured us staffing levels and staff deployment across the home's three floors were monitored and adjusted, on an ongoing basis, in line with people's current needs. They explained they also took into account feedback from people, their relatives, community professionals and staff themselves on the adequacy of staffing levels. During our inspection visits, we found there were enough staff on duty to respond to people's needs and requests without unreasonable delay, and that staff were deployed effectively across the home's three floors.

People felt safe and well cared for at the home. One person told us, "The carers (staff) are all lovely and they look after me and keep me safe." Another person said, "I am happy here. I like the carers (staff), and they are all nice and look after me." People's relatives were confident their loved ones received safe care and support. One relative explained, "I'm convinced [person] is safe. I have seen them being hoisted; [there are] never any issues. Staff are always kind and respectful." People's relatives were also satisfied with the steps

taken to manage specific risks associated with their loved ones' individual care and support needs. One relative described the measures in place to reduce the risk of their loved one injuring themselves in a fall. They told us, "[Person] has fallen out of bed in the past … they [provider] have lowered the bed and put a crash mat down."

Staff received training in, and understood, their individual responsibilities to remain alert to, and protect people from, any form of abuse or discrimination. They were aware of the different forms and potential signs of abuse to look out for. Staff told us they would immediately report any abuse concerns to the nurse in charge or management team, and had confidence these would be acted upon. One staff member said, "I have never seen any abuse by staff on residents in the four years I have worked here. I'm confident management would deal with it and not brush concerns under the carpet."

Staff told us they were kept up to date with any changes in the risks to people, visitors or themselves through, amongst other things, the daily 'handovers' organised between shifts. They were aware of the provider's procedures for reporting and recording any accidents, incidents or unexplained injuries involving people living at the home. We saw the management team reviewed these reports on an ongoing basis. Where necessary, they undertook further investigations and sought advice from external professionals to identify potential learning and prevent things from happening again.

When recruiting new staff, the provider completed pre-employment checks to ensure they were safe to work with people. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in April 2018, we rated this key question as 'Good'. At this inspection, we found improvements in the service were needed. The rating for this key question is now 'Requires Improvement'.

Upon starting work at the home, all new staff completed the provider's induction training to help them settle into their new roles. Staff spoke positively about their induction experience with the provider. This had included the opportunity to work alongside and gain experience from colleagues, and complete key initial training to enable them to work safely. However, we found staff lacked awareness of the Care Certificate. The Care Certificate is a set of agreed standards that should be covered in the induction of all new care staff. The registered manager acknowledged that, whilst staff e-leaning (online) training incorporated the requirements of the Care Certificate, new staff had not consistently completed this training. They assured us they would address this issue as a matter of priority, to ensure staff were consistently inducted in line with the requirements of the Care Certificate. We will follow this up at our next inspection.

Following induction, staff participated in an ongoing programme of training and refresher training, designed to give them the knowledge and skills needed to succeed in their roles. People, their relatives and the community professionals we spoke with had confidence in the overall competence of staff working at the home. One relative told us, "They [staff] seem very experienced and they are all very friendly." A community social care professional told us, "They [staff] all seem competent. I've seen them working in a kind and patient manner with some difficult people." Staff spoke positively about their training with the provider and the scope for them to request additional training to help them work more effectively. One staff member told us, "I've had the right training and learning; it's a continuous process and I'm still learning from my experiences at the home." We found the staff training records made available to us during our inspection were not fully accurate and up-to-date. The registered manager assured us they would address this issue as a matter of priority to assist them in monitoring staff training needs.

Staff told us they felt able to approach a senior colleague, nurse or member of the management team at any time for work-related support and advice. The registered manager and deputy manager provided 24-hour on-call support enabling staff to seek any urgent guidance and advice at any time outside of office hours. However, staff informed us they had not had the opportunity to have formal one-to-one meetings ('supervisions') with the management team on a regular basis. This included a lack of formal clinical supervision with nursing staff. Formal supervision has many benefits for staff, their managers and, most importantly, the people being supported by a service. Amongst other things, it provides an opportunity for staff to reflect on and review their practice, set performance objectives and identify any additional training and development needs. The purpose of clinical supervision is to provide a safe and confidential environment for nursing staff to reflect on and discuss their work and their personal and professional responses to this. We discussed these issues with the registered manager, who acknowledged that staff supervision and appraisal had lapsed since the start of this year. They assured us they would address this as a matter of priority to ensure documented staff supervision and appraisal took place on a consistent basis moving forward. We will check this at our next inspection.

We looked at how the adaptation, design and decoration of the premises reflected people's individual needs. We found there were suitable arrangements in place, and appropriate space available, for people to eat in comfort, participate in leisure activities, receive visitors or spend time alone. A refurbishment programme was underway to improve the overall of standard of accommodation, which had led to the upgrading of a number of bathrooms and bedrooms since our last inspection. We saw the corridor carpets on the home's top floor were still very worn. The registered manager assured there were plans in place to replace the flooring in this and other areas of the home in the coming months.

Certain steps had been taken to adapt the premises to the needs of the significant proportion of people at the home who were living with dementia. These included improvements in lighting, a varied colour scheme for people's bedroom doors and the availability of some reminiscence and sensory items, such as fidget mats. However, further work was needed to create a dementia-friendly environment. This was reflected, amongst other things, in the lack of clear, dementia-friendly signage to help people living with dementia to navigate their way around the home. We discussed this issue with the registered manager. They assured us plans were in place to create an environment that more fully reflected the needs of people with dementia, and that they and the provider had undertaken research on this subject. We will follow this up at our next inspection.

People's individual needs and requirements were assessed before they began using the service through meeting with them and, where appropriate, their relatives and the community professionals involved in their care. The management team recognised the need to avoid any form of discrimination in the planning or delivery of people's care, though taking into account people's protected characteristics. Staff and management liaised with a range of community health and social care professionals to promote a joined-up approach towards people's care and ensure people had access to appropriate specialist care equipment.

People and their relatives expressed satisfaction with the quality of the food and drink on offer at the home. One relative told us, "The food is good. Our relative always eats it and sometimes they have seconds. We feel there is a good selection and it looks very nice." Another relative said, "The food looks fantastic from what we have seen." The home's three-week menu system of freshly-prepared meals had been developed incorporating feedback from people themselves. A choice of food and drink was available at each of the three main meals each day, and staff helped people choose what they wanted to eat and drink. We saw mealtimes were unrushed and social events, during which people were provided with any physical assistance needed to eat safely and comfortably. People had access to plenty of drinks and snacks in between their meals. A relative told us, "The carers always offer us and our relative drinks regularly throughout the day: apple juice, strawberry milkshake, hot chocolate - all their favourites." Another relative said, "They [staff] are very attentive. They make sure [person] drinks; it's not a case of simply leaving the drink."

Any complex needs or risks associated with people's eating and drinking were assessed with appropriate advice from nutrition specialists, such as the local speech and language team. The management team put plans in place to manage these needs and risks through, for example, providing specialist or texture-modified diets, thickened fluids, and the monitoring of people's daily food and fluid intake.

People's relatives spoke positively about the role staff played in monitoring their loved ones' general health and supporting them to access healthcare services. One relative told us, "I have no worries about [person's] health needs; they [staff] are very much on the ball. If there are any health issues, they call the GP immediately, such as the recent eye and chest problems my relative had. They actively monitor [person's] health…" Another relative said, "They [staff] seem to notice things very quickly; they are on the ball regarding urinary tract and chest infections … When [person] has an outside appointment, they

[management team] organise transport and a carer goes with them." A local GP carried out a weekly visit at the service to review people's current health needs. The provider organised ongoing training for nursing staff to ensure they had the knowledge and skills needed to meet people's clinical care needs on a day-to-day basis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being. We saw examples of individual mental capacity assessments and best-interest decision-making in people's care records, where important decisions had needed to be made about their care. This included the proposed use of restrictions, such as bed rails, stair gates and locked doors. The management team had submitted DoLS applications based upon an assessment of people's mental capacity and their individual care arrangements. Where DoLS authorisations had been granted, they understood the need to review and comply with any associated conditions.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in April 2018, we rated this key question as 'Requires Improvement'. At this inspection, we found improvement in the service was still needed to ensure people's right to privacy was protected. The rating for this key question remains 'Requires Improvement'.

At our last inspection, we found staff did not fully protect people's rights to privacy and dignity. People's care records were left unsecured in a communal area of the home where they could potentially be accessed by unauthorised persons. At this inspection, people and their relatives described how staff respected people's need for privacy, dignity and independence. One person told us, "I have a bit of help with getting dressed but do most of it myself." A relative said, "They [staff] are respectful of privacy and dignity. They close the bedroom door and curtains and we leave the room when they do [person's] personal care." The staff we spoke with told us they understood the importance of treating people in a respectful and dignified manner, and gave us examples of how they did this in their day-to-day work with people. One staff member explained, "Privacy and dignity is about maintaining people's privacy, we ensure doors and curtains are closed and that people are covered up. I also knock on doors before entering bedrooms. … We encourage people to be independent to improve the quality of their lives, such as encouraging them to wash and dress themselves."

However, we found staff still did not always protect people's personal information. A range of confidential information relating to people's day-to-day care, including staff's daily handover records, had been left unsecured in the ground-floor dining room. We discussed this issue with the registered manager who assured us staff had received training on the importance of maintaining confidentiality at work. They assured us they would provide staff with additional training and support in this area, to ensure people's right to privacy was consistently protected.

This was a breach of Regulation 10 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. Staff had not ensured the privacy of the people who used the service.

People, their relatives and community professionals told us staff were caring in their approach, and took the time to get to know people as individuals. One person said, "The carers are all very nice and caring, they get me drinks and help me if I need anything." One person's friend told us, "When I visit, they [staff] seem to care for people, and they always make me feel welcome." A community professional explained, "I've dealt with the administrative staff, care staff and nurses. They are all very helpful, treat people with respect and seem to care." During our inspection visits, we saw a number of caring interactions between individual staff and the people who lived at the home. People were clearly at ease in the presence of the staff supporting them. Staff addressed people in a polite and respectful manner, and were attentive to their needs and requests.

Most people and their relatives were satisfied with the support they had to express their opinions about the service provided and participate in decision-making that affected them. One relative told us, "We are very involved in our relative's care. We are consulted and kept informed." The registered manager explained they had discontinued the home's 'residents' meetings' due to poor attendance. They had an 'open door' policy

and encouraged people and their relatives to approach them at any time with any suggestions or concerns. In addition, people and their relatives could provide feedback on the service through using the suggestions box in the home or completing an online survey form. The management team had developed links with local advocacy services and supported people to access an advocate whenever required to ensure their voices were heard in relation to any important decisions affecting them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2018, we rated this key question as 'Requires Improvement'. At this inspection, we found further improvement in the service was still needed. The rating for this key question remains 'Requires Improvement'.

At our last inspection, we found people needed more support to participate in recreational activities that reflected their needs and interests. At this inspection, people and their relatives continued to express mixed views about this aspect of the service provided. One relative explained, "The carers come in and sit with [person] to keep them company throughout the day … I have seen the residents play bingo and snakes and ladders. They were painting eggs at Easter and baubles for the tree at Christmas. [There are] exercise [sessions], skittles and they have pamper days for the residents and paint their nails." However, another relative said, "It used to be fine here, but now there is nothing for [person] to do, I have complained to the manager regarding activities and I have been reassured that there is another new activities person, but nothing has changed."

The provider employed two part-time activities coordinators who were responsible for organising a programme of activities for people across six days each week. These activities included occasional visits from outside entertainers, in-house games, baking, fun exercise sessions, arts and crafts activities, pub trips and one-to-one time with people who were cared for in bed. On the first of our inspection visits, we found there were no structured activities taking place as the activities coordinator was off sick. During our next visit, we saw people enjoying a game of snakes and ladders with the activities coordinator. We discussed the mixed views expressed about activities provision at the home with the registered manager. They assured us plans were in place to further improve the range of activities on offer, which included making fuller use of the 'activities room' on the home's middle floor. We will follow up on any improvement in the support people had to pursue their interests and take part in activities they found interesting and enjoyable at our next inspection.

People's relatives were satisfied with the opportunities they had to contribute towards their loved ones' care plans and participate in care review meetings. At the time of our inspection, the provider was transferring people's care records onto an electronic care management system to improve the overall standard of assessment and care planning. People's care plans dealt with important aspects of their care, including their personal safety, mobility needs, vulnerability to skin breakdown, nutrition and hydration and any challenging behaviour displayed. Staff confirmed they were given the opportunity to read people's care plans and refer back to these as needed.

However, the information in people's care plans was not always accurate or sufficiently personalised, and included little information about people's known wishes and preferences. For example, one person's medication care plan informed staff of the action to take if they became resistant to taking their medicines. However, procedures were already in place to administer this person's medicines covertly following best-interest decision-making involving their GP. The registered manager and nursing staff acknowledged the need for improvements in people's electronic care plans. The registered manager informed us these would

be fully reviewed in the coming weeks to ensure they were accurate, up-to-date and supported a person-centred approach towards people's care.

We found the management team and nurses lacked sufficient insight into the Accessible Information Standard, to ensure they were meeting its requirements. The Accessible Information Standard tells organisations what they need to do make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. The registered manager assured us they would research, and provide staff with training on, the Standard as a matter of priority. However, steps had been taken to assess and meet people's information and communication needs. People's care plans included guidance for staff on how to promote effective communication with individuals. In addition, people were supported to access audiobooks from the local library and pictorial meal cards had been produced to help people choose what they wanted to eat. The registered manager also described their work with a national charity for people with sensory impairments in response to an individual's specific communication needs.

At the time of our inspection, the service was working towards accreditation under the Gold Standards Framework in end-of-life care, which they were due to complete in January 2019. The management team had recently started end-of-life training which was due to be rolled out to all staff. We spoke with the relative of one person who was currently receiving palliative care at the home. They told us, "They have been fabulous; the staff are really lovely. We are so glad [person] is here." They commented on the kindness and attentiveness of staff in caring for their loved one in their bed. However, we found the provider needed to be more proactive in identifying people's preferences and choices for their end-of-life care, through discussion with them and their relatives. Following our inspection, the registered manager confirmed they were introducing a new template for recording these discussions on the electronic care management system.

Most people and relatives we spoke with were satisfied the overall care and support staff provided reflected people's individual needs and preferences. One person explained, "I get up and go to bed when I choose; the carers [staff] ask me what time. They help me choose what I want to wear for the day and they help me get washed and dressed. They are very good, helpful, patient and kind." During our inspection visits, we saw staff prioritised people's needs and requests, and adjusted their communication and the practical support provided to suit individual needs.

Staff received training on equality and diversity to help them understand people's protected characteristics under the Equality Act 2010 and avoid any form of discrimination in their work. They spoke positively about the extent to which the culture of the home valued people's individual differences. One staff member explained, "There is a very positive culture in the home towards diversity. We have staff who are from different cultures.; everybody is supported. I think the home does promote diversity and equality very positively. I have never seen anything of concern." During our inspection visits, one person was receiving a visit from friends belonging to their local church. One of these friends told us, "We are always welcomed at the door and shown around. They [staff] are very helpful."

People and their relatives told us they knew how to raise any concerns or complaints with the provider, and felt comfortable doing so. The provider had a complaints procedure in place to encourage good complaints handlings. We looked at the provider's complaints records and found complaints had been recorded and investigated in line with the provider's procedure and, where necessary, an apology issued to the complainant.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection in April 2018, we rated this key question as 'Good'. At this inspection, we found improvements were needed in the service. The rating for this key question is now 'Requires Improvement'

During our inspection we met with the registered manager of the service. They spoke about their work with clear commitment and insight into the individual personalities, needs and preferences of the people living at the home. The registered manager confirmed they had the support and resources they needed from the provider to deliver high-quality care and drive improvements in the service. They explained they kept themselves up to date with best practice guidelines through, amongst other things, attending events organised by the local authority and local clinical commissioning group (CCG).

Providers' registration with CQC requires them to notify us about certain changes, events and incidents that affect their service or the people who use it. These 'statutory notifications' play a key role in our ongoing monitoring of services. During our inspection visits, we found the provider had failed to notify us of a serious injury to a person who used the service, which was first noted in July 2018. The registered manager explained they had not identified and notified us of this injury at the time, as it had not been recorded in line with the provider's expectations by the nursing staff. We also identified the provider had failed to notify us of a safeguarding concern involving a person living at the home in June 2018. This related to the individual in question leaving the home unnoticed by staff and being returned by a neighbour a few minutes later. The registered manager told us we had not been informed of this incident due to an oversight on their part.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider carried out a range of audits and checks designed to ensure people received safe, effective and high-quality care. These included monthly audits targeted on the safe management of people's medicines, kitchen hygiene, broader infection control practices and the overall condition of the premises and care equipment. In addition, the registered manager carried out monthly analysis of any accidents, incidents, unexplained injuries and complaints to identify and address any patterns or trends. The provider's quality assurance framework also included regular audits by the owners of the care home.

However, we found the provider's governance and quality assurance systems were not sufficiently effective and robust. They had not enabled the provider to identify and address the shortfalls in quality we identified during our inspection, including the lack of consistent staff induction, supervision and appraisal and the omitted statutory notifications. In addition, this was the second consecutive comprehensive inspection at which the service had been given an overall rating of 'requires improvement'.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's quality assurance systems and processes were not as effective as they needed to be.

Most people and their relatives we spoke with talked positively about the overall quality of the care and

support provided. One person told us, "I have lived here quite a while and I would say I was happy here." A relative said, "We were so pleased that [person] was able to come to this nursing home … We are very happy they are here, and we would certainly know if they were unhappy." People and their relatives knew who the registered manager was and felt able to approach them with any suggestions or concerns. One relative explained, "We do know the manager and if we did have a need to voice concerns or had any issues we would speak to them or [nurse's name]." Another relative said, "They [management team] are lovely and very approachable." People's relatives felt communication with staff and management was good. One relative told us, "When we come to visit they let us know how our relative has been and if there are any changes or updates the home will call and let us know."

The community health and social professionals we spoke with also commented positively on their dealings with the management team to date, using words like 'helpful' and 'professional' to describe the registered manager. A research nurse praised the willingness staff and management had shown in participating in a study on the reduction of antibiotics in nursing homes. They told us, "I am just so impressed with the home. It seems very organised and the residents seem well cared for … It was a delight to work with them."

Staff spoke about their work for the provider with enthusiasm. Both nurses and care staff felt well-supported by an approachable management team who were supportive, willing to listen and who valued their individual opinions and efforts. One staff member told us, "I do feel genuinely valued and supported; I have no concerns with the management of the home. You can speak your mind, it's a very friendly, relaxed environment, as a home should be." Another staff member said, "The manager listens and takes on board our views. They also ask our opinions. I would be confident to approach them about anything." A further member of staff told us, "You can speak your mind and you are listened to. There is a good transparent culture here."

The provider took steps to involve people, their relatives and staff in the service. They achieved this through, amongst other things, organising regular staff meeting and online surveys for people to and their relative to give feedback on the home at any time. The management team took steps to maintain and develop community links to benefit the people living at the home. This included organising work placements for students from a local college and school, and welcoming local schools and church groups into the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff had not ensured the privacy of the people who used the service.