Ealing Eventide Homes Limited

# Ealing Eventide Homes Limited - Downhurst

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Ealing Eventide Homes Limited – Downhurst is a care home for up to 26 older people. At the time of our inspection, 20 people were living at the service. Some people were living with the experience of dementia. The service is managed by Ealing Eventide Homes Limited, a charitable organisation. This is their only registered care home.

People's experience of using this service and what we found
The provider had not always ensured risks to people were assessed, monitored or managed. Care plans and risk assessments were not always updated following a fall to ensure any lessons learned in relation to reducing the risk of reoccurrence had been identified and communicated to care workers. Medicines were not always administered safely and recorded to make sure people always received their medicines as prescribed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. This was because mental capacity assessments were not completed appropriately.

People's care plans did not always reflect their current care needs and care plans did not always provide care worker's with adequate information on people's wishes and preferences in relation to how they wanted their care provided.

Although there had been some improvements in the provider's quality assurance processes, further work was required to ensure these were robust and effective enough to identify areas for improvements so the necessary remedial action could be taken.

The provider had made improvements to staffing levels and the management team. There was now a registered manager and deputy manager in post and they were in the process of making improvements in relation to the oversight of the home. The staffing rota demonstrated the number of staff on duty was in line with the assessed staffing requirements for the service. Training records demonstrated care workers had completed the training identified as mandatory by the provider.

The provider was in the process of making improvements to the home's environment to make it more dementia friendly and to ensure it complied with fire safety regulations. People's care plans identified their food preferences and any specific dietary requirements. People were supported to access healthcare and other professionals when required.

The provider had an infection prevention and control (IPC) policy and procedures in place and had developed COVID-19 risk assessments for people living at the home and staff. Staff had completed infection

control training and we found they complied with safe IPC practices.

Despite the concerns we found at the inspection, relatives told us they felt their family member/friend was safe, living at the home and care workers provided support in a kind and caring way. We saw individual care workers providing support in a caring, polite and respectful manner. People's religious preference were identified and supported.

The provider had a complaints process and relatives confirmed they knew how to raise any concerns. Relatives felt the provider was making improvements since the previous inspection and felt positively about the registered manager.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 15 October 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches of regulations in relation to person-centred care, consent to care and treatment, safe care and treatment and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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

# Ealing Eventide Homes Limited - Downhurst

**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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors, and a medicines specialist advisor. An Expert by Experience supported the inspection by contacting the relatives (and friends) of people who used the service after our visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ealing Eventide Homes Limited – Downhurst 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the first day of the inspection 3 April 2022 and was announced on the 4 and 5 April 2022.
What we did before the inspection
We reviewed information we had received about the service since the last inspection which included information from meetings with the provider and the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with the registered manager, deputy manager, the nominated individual and four care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two people living at the home during the inspection and eight relatives/friends of people following the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included eight people's care records in full and aspects of another seven people's care plans. These included both electronic and paper records. We also reviewed multiple medicines records. We looked at six staff files in relation to recruitment and staff supervision and the training records for all staff working at the home.  A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider did not ensure people's medicines were always administered as prescribed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• At the inspection in August 2021 we found the provider did not always ensure people's medicines were administered as prescribed and in an appropriate manner. During this inspection we found some improvements had been made but a number of issues were identified in relation to how medicines were administered, and the relevant records completed, which continued to pose risks to people using the service.
• If a medicine had been prescribed to be administered at a specific time, we saw the records could not demonstrate this was happening. The medicines administration records (MAR) for one person showed they had been prescribed two time sensitive medicines with the administration times identified by the prescriber but these were not the same as the times recorded on the MAR chart when the medicines were administered. Therefore, the two medicines were being administered at times different to the time the prescriber had requested. This meant the medicines may not have been administered at the time prescribed, so people received the full benefits of the medicines. The deputy manager explained this has been raised with the supplying pharmacy, but an amended MAR chart had not been received from the pharmacy to reflect the times identified by the prescriber that the medicines should be administered. The issue was rectified with pharmacy during the inspection.
• The MAR chart for one person indicated that a prescribed calcium medicine had been signed as administered on two days, but we found the tablets were still in the packaging so had not been administered. This had not been identified and reported to the manager. The MAR chart for the same person indicated that an antibiotic which had been prescribed as requiring one tablet to be administered twice a day had been given once a day for 18 days. The MAR chart also included a duplicate record for the medicine covering an eight day period which overlapped and appeared to show the medicine had been administered three times a day. Therefore, the records in relation to this medicine were not accurate and the provider could not ensure the directions of the prescriber were followed.
• The MAR chart for another person indicated their medicines could be crushed. We saw that the medicines section in the person's care plan only stated medicines needed to be administered but there was no information about crushing them. Also, a risk management plan for crushing medicines with guidance for care workers was not in place.

• The MAR chart for one person indicated they had been prescribed a medicine to prevent blood clots and one to manage acid reflux which according to the instructions on the MAR chart should have been stopped on 13 December 2021. It was recorded on the MAR chart that the medicines continued to be ordered and administered to the person until 10 March 2022, even though the provider had requested a review of the medicines by the GP on 4 February 2022 followed on by another request on 9 March 2022. This meant that despite conflicting information the service continued to administer the medicines and had not given the issue enough attention and urgency to make sure it was safe to continue to administer the medicines to the person. Therefore, the registered manager had not ensured action was taken in a timely manner to ensure people always received their medicines as safely as possible.
• The information on some of the MAR charts we reviewed were handwritten and did not always provide accurate information on how a medicine should be administered. We saw the MAR chart for one person who had been prescribed a medicine to help with strengthening bones did not indicate the medicine should not be chewed.
• Medicines risk assessments had not been completed to identify issues in relation to the prescribed medicines and their administration. The only medicines risk assessment which had been completed was one which identified if the person could manage their own medicines. The majority of people at the home had their medicines administered by senior care workers so it only indicated that the person could not manage their medicines but did not identify any associated risks. For example, where a person had been prescribed time sensitive medicines their risk assessment only stated care staff were to administer medicines following the MAR chart but did not identify possible risks if the medicines were not administered as prescribed.
• We saw a device to crush tablets had not been cleaned between each use which meant traces of other medicines could transfer to other tablets. An aero chamber (a device which can be used when administering an inhaler) was found to be soiled and did not appear to have been cleaned in line with the manufacturer's instructions. This meant there was a risk of a build up of medicines on the device or risk of an infection as it had not been cleaned.

We found no evidence that people had been harmed. However, the provider had not ensured that people were always protected against the risks associated with medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The medicines room, the trolley and the medicines fridge were locked when not in use.
• Where a person had been prescribed a medicine to be administered as and when required a protocol had been developed to provide guidance for the senior care workers.
• Where a medicine had to be disposed of after a specific time period the date of opening was recorded on the packaging.
• When medicines were delivered using a transdermal patch it was recorded on the MAR chart when the patch was applied and a patch chart was also completed identifying where it was placed on the person's body and the date of application.
• Following the inspection, the provider showed us an incident report had been completed in relation to the incident where a person had not received their medicine for two days and the action they had taken to reduce the risk of reoccurrence had been recorded.
• Following the inspection the manager showed us they had developed a risk management plan for crushing medicines and updated the care plan for one of the people using the service to reflect the guidance for crushing of medicines.

Assessing risk, safety monitoring and management
At our last inspection the provider did not ensure that risks were identified, monitored and mitigated. This

was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• At the inspection in August 2021 we found the provider had not ensured risks had been assessed, reviewed or had taken actions to mitigate possible risks. During this inspection we found there had been improvements, but the provider had not fully implemented systems to ensure risks were identified and appropriately assessed and mitigated to help protect people against the risk of avoidable harm.
• The care plan for one person identified they were living with a catheter but a risk management plan had not been developed to provide care workers with guidance on how to manage any related risks.
• The registered manager confirmed three people used bed rails and five people used pressure relieving mattresses to reduce their risk of developing skin integrity issues. We reviewed the risk assessments and care plans for these people and found the use of bed rails or pressure mattresses was not referred to in the care plans and there were no risk assessments or management plans in place for the use of this equipment. This meant care workers were not always provided with guidance in relation to the safe use of equipment.
• The provider had developed risk assessments for people who could access the stairs around the home to mitigate against the risk of falling down the stairs, but we identified one person whose stairs risk assessment had not identified all the risks in relation to stairs. The risk assessment identified the actions being taken to reduce risk included the use of keypad-controlled doors and stated these prevented the person from accessing the stairs when unaccompanied. The person's bedroom was located at the top of a stairwell and was next to a keypad-controlled door. This meant the person, who used a mobility aid, could leave their bedroom and immediately access the stairwell as it was not restricted by a door. Also, due to the location of the bedroom if the person wanted to leave their bedroom, they would need to use the call bell to alert staff they required support. This was not included in the risk assessment as a possible issue with guidance for staff on how to reduce this risk.
• A newsletter we saw indicated a group of children had visited the home and the registered manager confirmed a second group of young people had also visited the home to sing. Risk assessments had not been completed in relation to the young people visiting and the people in the home to ensure both groups of people's safety had been considered by ensuring any risks related to the visits were identified and mitigation plans put in place to reduce those risks.

The provider had not ensured systems were in place to identify and provide mitigation for risks. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There was a range of general risk assessments that had been completed for people using the service. These risk assessments included nutrition, falls, dependency assessments and mobility.
• Each person at the home had a personal emergency evacuation plan (PEEPs) developed which included detailed information on how people should be supported if there was an emergency at the home.
• The stair sensor system had been removed and replaced with keypad access on fire doors in corridors and to access the lifts. The keypads reduced the risk of falls for other people who were at increased risk and people who had been identified as not requiring support with the use of stairs received the keypads numbers so they could move without restrictions in the home.
• Risk assessments had been developed for people who were able to access the stairs without support from care workers as well as people who had been identified as being at risk
• Risk assessments and management plans had been developed in relation to medical conditions people were living with such as dementia which provided guidance for care workers on how to support the person.

• We found hazardous items and substances including combustible material were now being stored securely.
• Risk assessments for the use of call bells had been developed and they included guidance on how to support people who were unable to use the call bells.
• The provider had taken steps to ensure actions had been taken to reduce the risk of injury caused by people's environment. Emergency exits were now clear to enable people to use them in case of a fire. Emergency evacuation equipment was now accessible with evacuation chairs and mats located around the home which could be easily accessed by staff. Staff had also completed training on the use of the evacuation equipment. Regular checks were carried out on the fire alarm system to ensure it was in good working order.
• Some people in the home were supported with their mobility by the use of a hoist. We saw two people had hoist slings in their bedrooms and we asked the registered manager how often the slings were washed and checked. The registered manager confirmed people had their own slings and the slings were washed but this was not recorded. Following the inspection, the registered manager informed us slings were washed when required and visually checked before use. They also stated they would introduce a system to record when the slings were washed or checked.

Learning lessons when things go wrong
At our last inspection the provider did not ensure actions to mitigate possible risks were identified within care plans and risk assessments were updated appropriately when things went wrong. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• The provider had a process for recording safeguarding incidents and other incidents and accidents, but we found that lessons learned had not always been identified. Also, care plans and risk assessments had not always been updated to reflect what had happened and any actions that should be taken to prevent further reoccurrence.
• The record of a safeguarding concern for one person indicated they had experienced a fall, but the falls risk assessment had not been updated and stated they had no history of falls. This meant care workers did not have the most up to date guidance to care for the person.
• The safeguarding record for another person indicated they had experienced a fall and a safeguarding referral had been made. The person's falls risk assessment had not been updated and stated they had not experienced any falls in the past year.

The provider had not ensured that lessons learned were always identified and care plans and risk assessments were updated to reflect when things went wrong. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the provider did not ensure that infection control processes were always robust. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to preventing and controlling infection.

• At the previous inspection in August 2021 we found the provider did not always take appropriate actions in relation to a range of infection control issues. These issues included personal protective equipment (PPE)

not being worn correctly, used PPE not being disposed of appropriately, food opening dates not recorded and COVID-19 risk assessments for people living at the home and staff not in place.
• At this inspection we found improvements to infection control practices had been made. We observed staff throughout the inspection and found they were wearing PPE in line with current guidance. We saw staff disposed of used PPE in the clinical waste bins. The registered manager confirmed there were supplies of gloves and aprons in each communal bathroom with clinical waste bins. Staff could access masks at the front door and in the office. One person we spoke with said, "Staff are very good about wearing masks and making sure visitors do as well."
• Training records showed that staff had completed infection control training which also covered the safe wearing and disposal of PPE.
• Food which had been stored in the fridges were clearly labelled with the date they were opened so staff could ensure the items were used within the manufacturer's guidance. The temperatures of the fridges were also monitored daily to ensure they were within an appropriate range to make sure food was kept at a safe temperature.
• The chairs in the lounge had been replaced and were now covered in a fabric which could be easily cleaned and there was no damage which make it difficult to maintain good infection control processes.
• The provider had developed COVID-19 risk assessments for people living at the home and for staff which identified possible risk factors including age, ethnicity and health conditions.
• The home was free from malodours, was clean and tidy and we saw regular cleaning was carried out.
• The provider had followed the visiting guidance and ensured any visitor to the home complied with the testing requirements and the use of PPE. One relative told us, "The home has managed COVID well and kept my [family member] safe. They have done this while being very sensitive to residents still needing to see friends and relatives. When the home did have COVID, people were isolated very quickly."

Staffing and recruitment
At our last inspection the provider did not ensure there was always sufficient skilled and experienced care workers deployed to meet people's support needs which placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• At the previous inspection in August 2021 we identified that the provider did not always ensure enough care workers were deployed to work to meet the provider's assessed staffing level. During this inspection the registered manager confirmed that during the day there should be one senior care worker, three care workers and an additional care worker allocated to provide one to one support for a person. At night there should be one senior care worker and two care workers on duty.
• We reviewed the staffing rotas from 7 February 2022 to 3 April 2022 and we saw the rotas indicated the staffing levels identified by the registered manager had been met for this time period. Care workers we spoke with told us they felt there was enough staff at the home. One care worker said "Yes enough staff. We can't rush. Many people we support in bed and another person in the shower, but no rushing because we have enough staff on. We are working as a team. Not perfect, if someone goes sick the management ask from the agency for support."
• The provider had a recruitment process which enabled them to check that new staff had the appropriate skills and knowledge for the role. We reviewed the recruitment records for two staff who were recruited since the last inspection in August 2021. We saw the checks carried out included obtaining two references, a record of the interview with the applicants, their right to work and a Disclosure and Barring Service check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment

decisions.
• The provider had profiles for the agency care workers who worked at the home which included the training completed, DBS status and eligibility to work in the country.

Systems and processes to safeguard people from the risk of abuse
• When a safeguarding concern had been identified we saw the provider had completed a safeguarding referral form with information on the issue and had informed the relevant local safeguarding team. We reviewed four concerns which had been reported to the safeguarding team and we found that a progress sheet has been completed showing each action in the process, but copies of correspondence had not been included in the safeguarding record. We informed the registered manager of this and they noted the information.
• Care workers we spoke with demonstrated a good understanding of safeguarding and what they needed to be aware of when providing support. The care workers confirmed they had completed safeguarding adults training. When asked what they would do if they felt there was a safeguarding concern, one care worker told us, "I would talk to the manager and see what the manager does and if they don't do something I would whistle blow and call CQC or go to the police if needed."
• Relatives we spoke with told us they felt their family member was safe at the home. One relative said, "I feel that [family member] is safe at Downhurst. The staff also navigated COVID-19 really well and did a great job."

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection the provider did not always ensure people were supported to make decisions about their care in line with the principles of the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

• Care was not always provided in the least restrictive way possible and within the principles of the MCA. At the inspection in August 2021 we found the ability of a person to consent to aspects of their care was not always assessed and when care was provided in the person's best interest the reasons for this decision were not always recorded.
• During this inspection we saw that assessments of a person's capacity to consent to aspects of their care were carried out, but these did not consider specific areas of the care provided and did not identify why the person was not able to consent.
• We looked at the records for four people and we saw the mental capacity assessments covered a number of aspects of the care they received which included personal care, administration of medicines, nutritional needs and moving and handling. These assessments included a section to check if the person could understand relevant information, retain this information, discuss the issues relating to the decision and if

the person could communicate their decision relating to an aspect of their care. We saw the assessment for one person which indicated they did not have capacity, just stated 'Asked [person's name] questions and [person] was unable to answer' and 'Asked the same question again and could not answer' but did not identify what questions were asked and how the person demonstrated they were unable to make a decision about their care. This meant the provider did not always evidence how the person could not consent to their care.
• Where the person had been identified as not being able to consent to aspects of their care, a best interest decision section was completed as part of the assessment. This section stated details should be recorded as the action to be taken with evidence as to why it was in the person's best interest. We saw that people's best interest decision section only provided a list of the care tasks and did not always provide evidence as to how the action would benefit the person. Therefore, the best interest decision did not always show how the proposed actions would be in the person's best interest.
• During the inspection we saw the provider had removed the movement sensor system on the stairs and had placed keypads on the internal fire doors along corridors leading to bedrooms. This meant people could not fully access the corridor if they did not have the keypad code. The use of sensors on people's bedroom doors and keypads on the fire doors could be seen as restricting a person's free movement. The provider could not demonstrate they had obtained consent from people to use the keypads and door sensors. The registered manager explained that, in relation to the keypads, people had been told the keypad code where it had been identified that they could remember the code. Where people could not consent to the use to the bedroom door sensors and the keypads to the doors in the corridors, the provider had not carried out a best interest decision for their use. This meant there was a risk the principles of the MCA were not being followed to ensure service users' rights to make decisions were always respected.
• The registered manager informed us two people had bed rails in use but the provider had not carried out an assessment to identify if the person could consent to their use and if the person could not consent, they had not undertaken a best interest decision.
• The MAR charts for one person indicated their medicines should be crushed when being administered. A mental capacity assessment had not been carried out to identify if the person could consent to this and if the person did not have capacity to make this decision a best interest decision had not been completed to show how this course of action would benefit the person.

The provider had not ensured people's rights to consent to their care were always respected and the principles of the MCA were always adhered to. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

• The provider had made applications for DoLS authorisations in relation to people who had been identified as not being able to consent to their care. When these applications were made it was recorded so they could be monitored.
• The care plans identified if a person had a Lasting Power of Attorney (LPA) in place so the relative or friend could be contacted when required. A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people to help them make decisions or to make decisions on their behalf.

Staff support: induction, training, skills and experience
At our last inspection the provider was unable to demonstrate that new staff members received regular support within their role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• The provider ensured that care workers received appropriate support and training for their role.
• We reviewed the induction records for two staff members who had been recruited since the last inspection in August 2021. Their records showed that they had completed an induction and had shadowed an experienced care worker for one shift. A direct observation of their skills and knowledge was also carried out as well as assessments of their competency in relation to moving and handling. Senior care workers were responsible for administering medicines and the registered manager demonstrated that they had carried out competency assessments in relation to medicines management.
• The registered manager provided the training records for all the staff working at the home which showed that the majority of staff had completed the training identified as mandatory by the provider. The records also showed that the majority of staff had completed a range of training courses which included basic life support, health and safety, fire awareness and moving and handling.
• Relatives told us they felt care workers received appropriate training with comments including, "I think that the skills that the staff have are very good, they seem to understand what they are doing. My [family member] has dementia, and they respond well to them, they are very good with [family member]" and "When I see a new member of staff, they do not seem to be phased by anything or lost. They seem to know what they are doing."

Adapting service, design, decoration to meet people's needs
At our last inspection the provider did not ensure the environment of the home was always appropriate and safe to meet people's care and support needs. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

• The registered manager had started the process of making the home environment safer and more dementia friendly to meet the needs of people living there. The tiled floor in the main corridor had been covered with dark coloured carpet tiles so it was no longer reflective, and the carpet was a non-slip material. The carpet on the main stairs had also been replaced with the same carpet tiles so the steps were easier to see, and flat. These changes meant a person living with a spatial awareness issue or visual impairments could see the floor more clearly and this could reduce the risk of falls.
• The bedroom doors had been painted different colours so they were more identifiable and people's names with pictures of people or items that were important to them, for example pictures related to a person's interests, job they did or family and friends were on the doors. This meant the doors were now personalised.
• New signage had been placed around the home which used pictures and large print and clear wording. These had also been laminated so they were easy to keep clean.
• The path around the garden appeared to have been made level to reduce the risk of falls for people using the garden.
• There was a CCTV system installed in the communal areas and the offices which recorded both sound and pictures. At the previous inspection there was no signage to inform people living at the home, staff and visitors that they were being recorded when they were in the communal areas. During this inspection we saw posters had been placed in communal areas in relation to the CCTV and the registered manager told us they had taken account of the guidance on the use of CCTV and surveillance when installing the system provided by the Information Commission's Office.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's support needs were identified before they moved into the home through an assessment process to ensure their care needs could be met. We reviewed the records for one person who had moved into the since the last inspection and we saw the information obtained though the needs assessment was used to

develop the care plan and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat foods which they enjoyed as well as meeting their dietary needs. Two people we spoke with told us, "I think the food is wholesome. It's good.  Very varied" and "It's edible. They send around a menu to fill in. Always a meat, fish and vegetarian. Same for puddings."
• Relatives we spoke with told us, "My [family member's] diet is very limited as there are lots of things they cannot eat, but the staff work around that and provide choices. The food seems to be very good and if my [family member] wants a snack in between meals, one is always available, they often eat in between meals. The kitchen bakes fresh cakes for the residents to have with their afternoon tea" and "My relative would not miss a cup of tea or a meal, they enjoy the food, has a choice; my [family member] has a cooked breakfast if they wish."
• The care plans identified people's food preferences as well as any specific diets they required and any allergies.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported by care workers to access healthcare and other services if a change in their care needs was identified.
• Records were maintained for each person which included copies of letters from healthcare professionals following hospital appointments, copies of discharge summaries and assessments from occupational therapy. We also saw records for visits from the podiatrist and for regular visits from the district nurse.
• Relatives confirmed their family member was supported to access healthcare when needed. Their comments included "If my [family member needs to attend hospital, the staff will arrange transport for them and will always contact the GP if needed" and "If my [family member]  needs the doctor or district nurse the home will always call them and then let me know. The interaction with medical services is very good and I will always receive an update when a doctor or nurse has been."

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 our last inspection we did not rate this key question. The rating for this key question at the previous inspection in March 2021 was requires improvement. The rating for this key question has remained 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; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

• Even though the provider had made some improvements at this inspection, we found that the service has not acted in a compassionate manner and have not shown enough concerns for people's wellbeing because there were still issues which had not been addressed in a timely manner by the provider to ensure people received good, safe and appropriate care and to make sure their rights were always upheld.

• A number of issues had been identified during the March 2021 and August 2021 inspection which were also identified at this inspection which demonstrated that the service was not always treating them with care and showing respect to them by making sure they always received care that was safe and appropriate. By the provider not ensuring they had done all that was reasonably possible to always ensure aspects of people's care met their support needs and risk management they could not be sure support to people was consistent and provided in a respectful way.

•Staff have not always responded in a compassionate and appropriate way to support people to manage symptoms associated with their medical conditions in that they have not made sure they always received their treatment and medicines in a timely manner.

•The provider could not always demonstrate they were supporting people to express their views and to be involved in decisions about aspects of their care because they had not always checked if people could make decisions and be involved in their care. Where the person could not make decisions, the provider did not always explore other ways where people could be involved and ensure action was taken in line with good practice.

• Notwithstanding the above, people we spoke with told us they felt the care workers were kind and caring. One person commented, "Staff are good. I wouldn't have their job for a million dollars. They are full of heart. You don't feel they are doing it because they have to. You can talk to them."

• Relatives we spoke with supported this and felt their family member was treated with dignity and respect by care workers who were kind and caring. Their comments included, "The staff are incredible, there are very kind people looking after my [family member], I really cannot fault them", "The home is a very happy place, everyone seems to be very comfortable, people are well cared for, are always clean and wearing clean clothes" and "The staff are very good, there are some staff who have been there a long time and others who are more transient. Any member of staff I have spoken to when visiting is courteous, chatty, and helpful."

• We saw care workers provided support to people in a kind and caring manner and were able to describe people's care needs in detail which demonstrated they had an understanding of people's care needs.

• People were supported in relation to their religious preferences. We saw that care plans did not always identify a person's religious preferences, but the registered manager and staff confirmed the home was visited by representatives of faith groups to meet people's religious needs.
• Relatives we spoke with felt the care workers supported their family member to maintain their independence. One relative commented, "My [family member] was not very mobile when they first went to live at Downhurst, but they have been very encouraging in getting [our family member/] back on their feet and [our family member] can now walk a few steps with their frame. The staff have worked very hard with them and have shown such a lot of patience." Care workers had completed equality and diversity training.
• Relatives confirmed they had been involved in the development of their family member's care plan. Their comments included, "When my [family member] went to live in the home we talked to the manager about their needs and discussed a plan of care" and "When [our family member] was first admitted we went through everything with the staff; all that they needed, and our views were listened to. If there are any changes, problems or issues the staff will always call me or have a discussion when I visit. Any decisions made about [our family member] are always made in full consultation with me"
• Relatives told us they were kept informed about their family member's care and anything they needed. Relatives comments included, "I am kept informed, and the staff will call me if my [family member] wishes me to bring something for them. The staff are incredibly cooperative" and "The staff called me the other day to ask me to bring [family member] some new slippers, they will let me know if they need anything at all."

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we did not rate this key question. The rating for this key question at the previous inspection in March 2021 was requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had not always ensured the care being provided was person-centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• At the previous inspection we found the provider did not always ensure care plans reflected people's care needs and how they wanted their care provided. At this inspection we found there had been some improvement as the provider had developed the electronic care plan system so care workers could access each person's care plan, risk assessments and record the care provided each day using a handheld device. However, we continued to identify concerns that people's care plans were not always followed, did not always reflect their current care needs and were not always person centred.
• The records for repositioning people to reduce the risk of developing pressure ulcers were not always completed to demonstrate how the person was supported in line with their care plan. The care plan for one person indicated they needed to be repositioned in bed as they were at increased risk of developing pressure ulcers. The continence section of the care plan stated the person should be repositioned every two hours whilst the skin integrity section stated repositioning should occur every four hours. Therefore, the guidance was not consistent. We reviewed the repositioning records for a seven-day period, and we saw the records indicated the person was not repositioned consistently in line with the guidance. On 23 March 2022 the record showed a 16-hour period where there was no indication of how the person was positioned, either in bed or an armchair, and if they had been supported to reposition as directed in the care plan. The care plan for a second person indicated they should be repositioned every four hours. We reviewed their repositioning records for a four-day period, and we saw there were gaps of up to nine hours with no indication of how the person was positioned. For example, on 2 April 2022 the person had been positioned on their back from 8.30am until 12.15am the next morning. This meant the care workers were not always following the guidance in the care plan to meet the person's support needs and reduce the risk of them developing pressure ulcers.
• The care plan for this person also indicated their weight should be monitored weekly with any concerns reported to the GP and their food and fluid should also be recorded daily. We saw the weight records for this person indicated their weight had been checked on 19 October 2021, 4 January 2022 and 15 February 2022.

This meant care workers or any other healthcare professional looking at the record would not have adequate information to monitor the person's weight. The food and fluid charts we looked at which covered the period between 22 March 2022 and 28 March 2022 were not always completed with some records not identifying what the person ate. For example, on 22 and 26 March there was no record to show if the person had breakfast. The records for the week also indicated that the person had been given snacks, but it was not always recorded what snacks were provided to give a full picture of what the person had eaten. As there was no evidence the person's weight was being monitored according to the care records, we could not be sure the person was receiving person centred care.

• The records of the personal care support provided were not always completed even though people's care plans stated they needed the assistance of care workers to complete these aspects of their care. For example, the care plan for one person indicated care workers should support them with a daily wash and to clean their teeth. The hygiene chart for March 2022 showed that a wash and oral care had not been recorded on 10 days during the month. The care plan for another person stated care workers should support the person with a shower every day but the hygiene records for March 2022 had not been completed for seven days.

• One person had experienced a fall and a referral had been made for an occupational therapy assessment. The outcome of the assessment was that two types of mobility equipment were recommended to assist the person's mobility. The registered manager explained that one piece of mobility equipment was being used with the person. This piece of equipment was not referred to in the person's care plan or their mobility care plan. Therefore, the care plan did not reflect the person's current mobility support needs and did not provide care workers with appropriate guidance on supporting the person with their mobility.

• Sections of people's care did not always provide care workers with appropriate information on how to provide support and reduce possible risk. For example, the 'maintain a safe environment' section in one person's care plan stated they wanted a daily newspaper with the outcome of this action being that the person wanted to live in a safe environment. There was no indication as to how this action was going to ensure the person was in a safe environment.

• The communication section in the care plan for one person indicated that they used lip reading and understood body language when communicating as they had a hearing impairment. There was no guidance in the care plan in relation to how to support the person to communicate when face masks are worn. We raised this with the registered manager who explained the person did not use lip reading to assist with communication therefore there was no issue relating to the use of face mask when communicating with this person. Therefore, the communication guidance in the care plan was not accurate to ensure the care workers provided appropriate support to the person.

The provider had not always ensured the information provided in care plans for care workers reflected the current care needs and the wishes of the person. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

• Prior to the inspection we received information that people living at the home were being supported to go to bed at a time chosen by the care workers and not at a time they wished. We started the unannounced inspection on a Sunday evening to assess if people were able to choose when they went to bed. We found 13 people in the lounge enjoying a drink following dinner and the people who were in their bedrooms had chosen to be there. Two people we spoke with during the inspection confirmed they could choose when they got up and when they went to bed. Therefore, people were supported to choose where they wanted to be following their evening meal.

• At the previous inspection we found that people's preferences in relation to their end of life care were not recorded. At this inspection we saw that most people had information relating to their wishes in the death and dying section of their care plan.

• We saw that the care plans for some people identified if they wished a representative of a specific religion

to be contacted, if the person wanted to continue receiving support at the home and who they wanted to be contacted if their health deteriorated.
• One relative told us, "We recently discussed a care plan regarding my [family member's/] wishes and plans should they pass away."
• Following the inspection the registered manager confirmed additional training on completing the electronic records of the care provided had been organised for care workers.
• Following the inspection the provider confirmed that the person's care plan had been updated to reflect their current communication support needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• People's communication needs were identified as part of the care plan. The communication section of the care plan included information relating to if the person had a visual or hearing impairment and if they wore glasses or a hearing aid. Information was also provided on which languages each person spoke and their preferred language.
• We saw where a person had difficulty with communicating verbally the care plan included guidance on how care workers could support the person by giving them time to respond to questions.
• The care plans also identified how care workers could support people if they experienced any agitation or became frustrated and found it difficult to explain what is wrong.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The activities organised at the home were not always meaningful and related to people's interests. During the inspection we observed staff had organised a game of skittles in the lounge during the morning which lasted 14 minutes. There were 13 people in the lounge and the activity only involved five people which meant seven people either did not or were not able to take part. During observations we saw that some people spent their time sleeping and where their care plan stated they liked reading we saw the person asleep in an armchair when care workers place a newspaper on the person's lap. Details of the activities which were organised and who took part were not recorded to enable the care workers to identify which activities were popular and who needed encouragement to take part.
• Two people we spoke with told us that "sometimes it is a bit boring" but they can go to their bedrooms to read or speak with relatives. When we asked relatives and friends about the activities we received mixed feedback which included, "My [family member] likes to walk in the garden and the staff encourage them to do this", "I think some of the entertainment has fallen off since the pandemic as people cannot come in. There are still some things going on organised by the activities co-ordinator such as ball games while sitting in the chair, bingo, making Easter bonnets and singalongs. A musician did visit the home a few weeks ago", "I usually visit in the afternoon and do not see any activities taking place, they may happen in the mornings, I am not sure" and "[Family member] is sometimes sitting alone, but in the midst of things, I do think there could be more 1:1 time, but I am not sure how the amount of 1:1 compares with other homes."
• We discussed activities with the registered manager, and they explained that specific staff had been identified to take the lead on activities and other care workers would provide support. They were looking at enhancing the skill set of the activities coordinator and developing a range of activities to meet the needs of everyone at the home.

• Relatives we spoke with confirmed they felt welcome when they visited their family member at the home. One relative commented, "The staff are very welcoming when I visit, I usually visit in my [family members] room and it has never been a problem, I am made to feel part of the Downhurst family."

We recommend the provider seek and implement national guidance on the provision of social and recreations activities for older people in care settings.

Improving care quality in response to complaints or concerns
• The provider had a process to investigate and respond to complaints. We reviewed the record for one complaint which had had been received since the last inspection. We saw the complaint was investigated, reviewed and corrective action was taken to address identified shortfalls.
• People we spoke with confirmed they knew how to raise any concerns they had with one person telling us, "If I had a complaint staff would listen. The deputy manager is very good. If anything is really bad, I would go to registered manager. Haven't had to."
• Relatives and friends of people living at the home also confirmed if they had any concerns, they would raise them with the home. Their comments included, "We have not had to complain, there has not been anything to complain about. The staff are very good at communicating with me and keeping me up to date" and "I would have no problem with complaining if I needed to. There is open communication at the home and if I were unhappy about anything I am quite confident that things would be dealt with."

Inadequate

# 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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At our last inspection we identified a number of both repeated and new shortfalls and we found that the provider's governance systems and their oversight of the service did provide the assurance that people would receive high quality, safe and appropriate care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• At this inspection we found the provider and the registered manager had introduced a range of new quality assurance processes, but these were not always robust enough to enable the provider to assess, monitor and make improvements to the service. There had been some improvements in relation to staff training, the deployment of staff and the environment of the home but the necessary changes in relation to the other concerns identified at the last inspection have not been made.
• The medicines audit, which the registered manager completed weekly, was not robust enough to identify possible medicines errors. The medicines audit reviewed all the medicines which were administered weekly, but it had not identified the issues we found during the inspection. We reviewed the MAR charts for January, February and March 2022 where we found several issues which included medicines not being administered as prescribed, stock of medicines not being available and the MAR charts not accurately showing when medicines were administered. The medicines audits had not identified the issues we found, and medicines errors were not always fully investigated which meant the provider could not ensure appropriate action was taken to resolve any issues.
• The registered manager completed a monthly trends analysis report reviewing the outcomes of other audits. We looked at the trends analysis reports completed for the four months before the inspection. We saw that the information recorded was not always accurate. In the February and March 2022 reports the section relating to nutritional status which identified how many people required pureed food or thickened fluids had not been completed. The records of care we reviewed indicated that at least one person was given pureed food which was not indicated in the reports. The falls figures in the February 2022 report stated no falls had occurred but in the overviews section there was a description of a fall which had occurred, so

the analysis was not accurate.
• A monthly care plan audit was carried out by the registered manager but there were no records to demonstrate when they had been reviewed and if any issues had been identified. We found a number of issues with the information in the care plans and risk assessments, for example updates not being completed following a fall and information not being up to date. This meant the provider could not demonstrate their care plans audits were effective.
• There had been some improvement in relation to the assessment and management of risk but we found there were still issues with the process used to identify a risk and ensure risk management plans had been developed with appropriate guidance for staff. We found that risks in relation to a medical condition, use of equipment, risk of falls related to the stairs and when specific groups of visitors came to the home, had not been assessed to ensure comprehensive risk assessments and management plans had been put in place to mitigate identified risks.
• The provider had not always analysed and reflected on the outcomes of incident and accident reports and safeguarding concerns so lessons could be learnt, and any trends identified. This meant the provider could not always feedback to the care workers on why something happened and how it could be prevented from reoccurring.
• Records of telephone consultations and discussion with the GP were not always recorded. The registered manager confirmed that the telephone discussions relating to people living at the home were not always noted to ensure there was a record of any input from the GP.
• The registered manager confirmed medicines competency assessments for senior care workers were undertaken by them and the deputy manager. We asked the registered manager what training they had undertaken to enable them to carry out the competency assessments and the registered manager confirmed they had not completed, any recent training and the deputy manager had only completed the in-house training. Therefore, the senior staff members carrying out the competency assessments for the administration of medicines could not demonstrate they were up to date with current best practice and skilled enough to train others and assess their competencies. During the inspection the registered manager contacted the local authority to identify any training which would assist them with the assessments.
• People's daily records of the care provided were not always completed in full and in a timely manner to demonstrate that care was provided as planned and required. There was sometimes a gap between the actual care delivered and the time it was recorded which meant the record was not always contemporaneous.

There were a number of continued shortfalls identified at this inspection which meant the provider had still not developed effective quality assurance and governance processes to assess, monitor and improve the quality of the service to ensure people always receive high quality and safe care. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

• Following the inspection, the provider told us they were implementing processes to improve records keeping in relation to communication with healthcare professionals about people's care.
• The provider is a charitable organisation which is managed by a board of trustees. At the last inspection we found that the provider did not have an effective management team to ensure people received safe and appropriate care. Since August 2021 the provider has appointed a registered manager, a deputy manager and the finance director has taken on the roles of nominated individual and chief executive officer. A relative we spoke with said, "A year ago there were clearly issues at management level, but they now seem on top of the management structure. There is a better line of communication and the management team is quick to respond."
• The relatives provided positive feedback about the registered manager and the senior staff which included, "I find the manager forthright and honest and see that she interacts with the residents extremely well, she always has time for them" and "The manager was very visible at first and if I want to see her, she will always

come out of her office. I do think the amount of change that was needed has occupied a lot of her time"
• Other audits had been introduced, for example a dignity in care audit, a monthly managers self-audit and a health and safety hazards audit. We noted that the audits had been completed regularly but were based on yes or no answers and additional information on who had been observed or where in the home had not been recorded to assist the provider in monitoring their quality assurance processes. We discussed this with the registered manager during the inspection.
• The provider had started a process to improve the home's environment which included making it more dementia friendly and improving the fire safety process and equipment in place.
• The provider had implemented a process to comply with the national guidance in relation to the use of CCTV in communal areas and the use of the footage obtained.
• The registered manager explained people's religious and cultural needs were identified as part of the initial need's assessment. The provider had arranged for people to be visited by a representative of their preferred religion. People were supported to attend church services.
• People living at the home and relatives were supported to provide feedback on the care provided. The registered manager said they were aiming to increase the frequency of meetings with relatives to three monthly as pandemic restrictions eased. Relatives confirmed there had been meetings with their comments including, "There have been some relatives' zoom meetings where mainly the CQC inspections have been discussed and various actions such as putting photographs on bedroom doors and new paperwork to complete. We were also introduced to the new manager", "I attended a relative's meeting last year and it was very good. [The registered manager] seemed very enthusiastic, driven, and keen to shape new staff" and "We have had relatives' meetings and I have always found the management team very frank and honest. They have outlined problems found during recent inspections and what they feel has gone wrong. The relatives have been universal in their support to keep the home open."
• We saw a survey had been carried out to obtain feedback from both people living at the home and relatives which was confirmed by a relative who said, "We received a questionnaire to complete sometime last year, it was a long survey; very detailed."
• The provider worked in partnership with other organisations. These included local schools, churches and attending training provided by the local authority.

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
• The registered manager demonstrated a clear understanding of the duty of candour and how it relates to their role. They told us duty of candour meant they had to ensure they were, "Open, honest, transparent with an open-door system. We don't try to hide anything. If something happened, it happened so get the help you need and inform the relatives."
• One relative commented, "If I had any worries, I would speak to the manager who I know would listen, she is a very receptive person."
• The provider had a range of policies and procedures in place which were reviewed annually or when required and updated if needed.
• The provider had a procedure to respond to complaints. When a concern was raised, we saw it was responded to in a timely manner and actions were identified so improvements could be made.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Relatives we contacted were happy with the care their family member received and they were positive about the changes made at the home since the previous inspection. Their comments included, "There has been real change since the new manager has been there. She is different in terms of enthusiasm to get things right and in her commitment to that", "The home runs very well, it is a very homely place, and the staff interact well and are extremely caring. I can visit whenever I wish to and when I do, I find my [family

member] very happy and comfortable" and "The manager is incredible, and the home has a lot more structure and organisation. Downhurst is always caring and homely and the manager has added a thoroughness to the professionalism. My [family member] always comments that it is a happy and caring place to live."

• Although we found concerns in the quality of service provided in several areas, there had been some improvement in relation to the processes in place to keep people safe and reduce possible risks. However, further work was required to make sure effective systems were in place to ensure people were always protected against the risks of inappropriate and unsafe care.