

Maria Mallaband 11 Limited

Brunel House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Brunel House is arranged over three floors and offers a service for up to 65 people across three units which include nursing and dementia care.

People's experience of using this service and what we found

We responded with an early morning visit due to concerns raised about staff getting people up too early. While four people were up when we visited, we found bedside lights and bedroom doors open on two floors. We spoke with the registered manager who investigated and gave us reassurances this practice was not usual.

Whilst the service had processes in place for the safe storage, administration and use of medicines, these were not always followed, in particular the ordering and stock control of medicines.

There was a large volume of waste medicines awaiting collection for disposal, indicating ineffective stock management.

Records showed that people did not always receive their medicines, due to stock not being available despite there being systems and process in place with the service, GP and community pharmacy.

Records also showed that people did not always receive their medicines as intended due to people sleeping, yet there was no evidence that there was a process in place for sleeping people to enable medicines to be offered once awake or where a persistent occurrence with an individual, a review to be undertaken with the prescriber to address this.

Individual risks were assessed and analysed. Where risks were identified there were preventative measures in place to reduce the risk. There were people who at times challenge the staff and placed themselves and others at risk of potential harm. Specific plans were not in place on how staff were to manage these situations. Incidents recorded in the behaviour charts (for direct observation used to collect information about the events of behaviours) were not analysed. We found descriptions of incidents recorded in behaviour charts were variable in quality of detail and the post incident consideration box was very rarely completed. There was little evidence that the behaviour charts were reviewed.

Despite the feedback from staff and relatives that staffing levels were not adequate, the registered manager said the staffing levels were above the dependency assessment of people's needs. Relatives and staff said more staff were needed. We have made a recommendation about the review of staffing levels.

Recruitment processes ensured the staff employed were suitable to work with people at risk

People's needs were assessed before their admission. Assessments included people's preferences,

relationships, hobbies and interests. Although care plans were more person centred, they were variable in quality and needed to improve to the same standard. We recommend that care plans are brought to the same upper standard.

People said they felt safe living at the home. Safeguarding processes and systems were in place. Staff were knowledgeable about the safeguarding of people at risk procedures.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Accidents and incidents were recorded investigated and analysed.

New staff attended an induction when they started work at the home. There were systems in place to support staff with their performance, to develop their skills and there were opportunities for personal development.

People told us the food was good and relatives said the food had improve. People were supported with their ongoing healthcare needs.

We saw examples of kind and caring staff. Relatives spoke highly of the care staff delivered. Staff were knowledgeable about people's preferences and how to build trust. Where people were receiving palliative care, their end of life care was pain free and dignified.

There were group activities which people who attended enjoyed. The recently appointed activities coordinator will develop one to one activities as this was not fully operational at the time of the inspection.

Relatives told us who they approached with complaints. Logs of complaints showed they were analysed and resolved.

The staff said the leadership qualities of the registered manager had improved the care delivery for people. The staff said the registered manager was "fantastic" but felt this registered manager was under pressure to meet targets. When we repeated the feedback from staff the registered manager disagreed with their comments that they were under pressure.

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 Requires Improvement (published 07 November 2018). 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 improvements had been made but the provider was still in breach of other regulation.

The service remains rated requires improvement. This service has been rated requires improvement for three consecutive inspections

Why we inspected

This was a planned inspection based on the previous rating.

The inspection was prompted in part due to concerns received about lack of staff at night. A decision was made for us carry out an early morning inspection to examine those risks.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.
Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.
Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below

Requires Improvement ●

Is the service well-led?

The service was not always well-led.
Details are in our well-Led findings below.

Requires Improvement ●

Brunel House

Detailed findings

Background to this inspection

The inspection

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

Inspection team

This inspection was unannounced on the first day and announced on the second day. This inspection was carried out by four inspectors including two medicines inspectors.

Service and service type

Brunel House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection

We spoke with four people who used the service and four relatives about their experience of the care provided. 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 spoke with eleven members of staff including senior carers, registered nurses, housekeeping staff and activities staff. We spoke with the registered manager and quality assurance managers. We also spoke with three health and social care professionals.

We reviewed a range of records. This included two people's care records and multiple medication records.

We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We inspected the storage of medicines, reviewed 11 medicines administration records (MARs) and care files of people within the service. We spoke with the registered manager, quality and compliance manager and members of care staff who were involved in the management of medicines. We reviewed a sample of recent medicines related audits and incidents reported within the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
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At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the last inspection dated September 2018, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to maintain accurate and up to date records. At this inspection we found the provider had met the requirements for records but was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

- Medicine systems were not always safely managed. There were stock ordering processes in place. However, we saw that medicines were not always given as they were not available.
- Records showed that people did not always receive their medicines as intended. We noted that 24 people within the service did not receive one or more of their medicines between 1st -16th October due to prescribed medicines not being available.
- The service were not always responsive to a person's needs and/or preferences when timing the administration of medicines. We noted that 25 people within the service did not receive one or more of their medicines between 1-16th October due to being asleep. However, the GP was not consulted on the flexibility of times medicines can be administered.
- Not all people within the service receiving covert administration had a documented review of their medicines by a pharmacist to ensure suitability. However, on the day of the inspection, we were told this was in progress.
- People's preferences and suitability for medicines administration were not documented for all people or always available for staff at the point of administration,

We found no evidence of people being harmed however, systems were either not in place or robust enough to demonstrate safe management of medicines. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- "When required" (PRN) protocols were comprehensive, and person centred. Whilst documentation relating to administration preferences wasn't readily available for everyone at the point of administration, enabling administration in a person-centred way, it is acknowledged that the service has an electronic MAR programme which does not have this functionality and therefore the service relies on paper-based documentation, which was usually documented within the care plans
- The provider responded immediately during and after the inspection. They confirmed there was a review

of their processes for ordering medicines with the supplying pharmacy to ensure the timely supply of people's medicines.

- The service had good systems and processes in place to ensure the safe and secure storage of medicines.

Staffing and recruitment

- Staffing levels were consistent with the dependency assessment of needs. The registered manager told us that the staffing levels were above the dependency assessments and were increased based on feedback. However, staff and relatives said more staff were needed to meet people's needs. A relative told us "sometimes it's frustrating trying to find staff." Another relative said "the staff are great but there are not enough".
- A member of staff said the unit would benefit from a "hostess" to support mealtimes. This member of staff said we work well together but it becomes stressful [because of poor staffing]. Another member of staff said because of the current staffing levels "it's difficult to accommodate people's preferences."
- People used the nurse call system to gain assistance from staff when they were in their bedrooms. During the morning we noted that the call bells had been going for prolonged periods. For example, one person's call for assistance was unanswered for 13 minutes. A member of staff said, "if the bells are going for a long time it's because the senior is doing medicines and two carers are delivering personal care."
- A registered nurse told us the nursing unit would benefit from an additional member of staff. They said there were people with complex health needs and some people needed two staff to deliver personal care. This member of staff said "we used to have four carers and one nurse when there were 16 people" accommodated in this unit. At the time of the inspection there were three staff and the registered nurse on duty for 19 people.

There was there was conflicting feedback from the provider, staff, people and relatives about staffing levels and meeting people's needs. We recommend that the provider reviews how they determine staffing levels, taking into account feedback from staff, people and their relatives.

- Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people

Systems and processes to safeguard people from the risk of abuse

- We responded to anonymous concerns raised to CQC prior to the inspection about staff "getting residents up washed and dressed from 5:30 am." When we arrived at 6:30am we found four people across three units were up, dressed and in communal areas. However, in two units we found the corridor lights were switch on brightly and all bedroom doors were open with bedside lights switched on. This meant there was potential to disturb people who were not ready to get up. For people with dementia there was little visual clues on the times of day. We asked staff about the rationale of having corridor and bedside lights switched on and bedroom doors open. The staff told us this were people's preferences. The registered manager conducted an investigation on why the lights were switched on and bedroom doors open and concluded this was not usual practice despite the comments from the staff.
- The people we spoke with said they felt safe living at the home. The relatives we spoke with said their relative was safe from potential harm. When we observed staff's engagement we saw people welcome interaction from staff.
- The safeguarding processes were displayed on notice boards. Safeguarding referrals were made when

appropriate. The staff we spoke with had attended training in safeguarding of people at risk of abuse procedures. They were able to describe the types of abuse and felt confident to report all forms of abuse including whistleblowing.

Assessing risk, safety monitoring and management

- There were people who at times expressed their anxiety and frustrations through behaviours that challenged staff and others. The guidance on triggers and ways people expressed distress was not detailed in care plans. Care plans lacked guidance on how staff were to manage situations when people showed signs of frustration and anxiety.
- The staff documented incidents when one person expressed their frustrations with behaviours that challenged them and others. The reports described the actions taken by staff when the person showed signs of frustrations such as diverting, swapping staff and moving people from the area. However, there was a lack of consistent approach for repeated patterns of behaviours.
- There was a lack of a consistent approach for the same patterns of behaviour. For example, the staff took various different actions when one person made attempts to enter the lift. The report showed staff had supported the person away from the lift on the three separate attempts made. They had not assessed the person was showing signs of wanting to go out and taking the person out for a walk was not considered. A member of staff said, "we are taking him for a walk but we are not writing it down." There was a lack of analysis of behaviours and staff were not provided with clear guidance on how to support the person when the same behaviours were expressed. The staff said the person was receiving one to one support.
- Risks were assessed and reviewed to ensure the actions were appropriate to the level of risk identified. The staff we spoke with were aware of people's individual risks and the risk reducing measures in place. For example, a member of staff said sensor mats were used for people at risk of falls and thickeners were used for people at risk of choking.

Preventing and controlling infection

- All areas of the home were clean and free from unpleasant odours. The staff had access to personal protective equipment.

Learning lessons when things go wrong

- Accidents and incidents were reported by staff. The reports detailed the actions taken by staff and any control measures implemented to address trends and patterns. For example, people were observed for 24 hours following a fall. For another person an analysis was taking place to evaluate the times when the person was more likely to fall.

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's healthcare was coordinated between the staff and health and social care professionals. People had access to community nurses, optician and dentists.
- The staff told us people were encouraged to maintain good oral health. While oral health assessments were completed the actions for the level of need identified had not been followed for one person. The assessment showed there was a deterioration in the person's oral health and the monthly monitoring scores had increased. There was no documented information that staff supported the person with oral health. The senior on duty confirmed a dentist was not requested and said they would arrange for a dental visit.
- A community nurse told us the staff made referrals to them in a timely manner and their advice was followed. This community nurse said the staff were always available to support their visits. They said this meant people were supported by familiar staff whenever nursing procedures were happening.
- Staff told us the GP visits were regular. A member of staff said routine visits took place twice weekly. Individual records of healthcare visits were maintained and detailed was the nature of the GP's visit and the advice given to staff.

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

- People's needs were assessed before they were admitted for care and treatment at the home. Pre-admission assessments were completed on all areas of people's needs, their likes and dislikes. For some people there was information on family networks and their hobbies.
- We noted National Institute for Health and Care Excellence (NICE) guidance and other professional bodies had been used to achieve effective outcomes for people.

Staff support: induction, training, skills and experience

- People's care and treatment was delivered by staff who were supported with their performance and with developing their skills.
- New staff said they had an induction when they started their employment at the home. The training matrix showed staff had attended mandatory and other training for their role. Mandatory training included medicine systems, safeguarding of people at risk, health and safety.
- A member of staff told us there was additional training which helped them with their personal development. This member of staff said that four seniors were registered on the care practitioner training. This meant seniors were able to support the nursing units.
- Some staff said one to one supervision with their line manager was regular. Where staff had regular one to one supervision they discussed policy changes and concerns. However, seniors said since the deputy's post

had become vacant their supervisions were not as regular. The registered manager agreed there had been delays with supervision meetings. The manager explained that once the deputy was in post staff supervision would be more regular.

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

- People told us the food had improved. One person said, "they are getting there." Another person said "I am fond of the food. There are nice treats I like avocado. I like all sorts of melons. I like bread and crumpets."
- The nutrition and hydration care plans gave guidance on how to assist people with maintaining a balanced diet that catered for their dietary needs. Assessments were completed and monitored to ensure changes of people's nutritional needs were identified and action taken. The nutritional assessment for one person had assessed them at low risk of malnutrition and the care plan listed their preferences on how their meals were to be served. For example, likes moist foods.
- We observed the lunchtime meal in the dementia unit. We saw four people having their lunch in the lounge. One person was being supported by staff, a relative supported a family member and two people were eating their meals independently with little supervision. There was a calm and unrushed atmosphere with staff offering discreet support. The member of staff assisting one person had a conversation about the meal. This person was asked if they wanted to taste the meal before assistance was provided. The member of staff asked the person if they had enough to eat at the end of the meal and excused themselves when they had completed the support to the person.

Adapting service, design, decoration to meet people's needs

- Brunel house was arranged over three floors with the nursing unit on the ground floor and nursing dementia on the lower ground floor.
- The home had level access, wide corridors, access by lift to all floors and all rooms were single and en-suite
- The lower ground floor was adapted for people with dementia and there was access into the garden.

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 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.

- Mental Capacity assessments were completed for specific decisions and best interest decisions taken where people lacked capacity. Copies of the lasting power of attorney were held where one was nominated.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The registered manager tracked DoLS in progress to ensure the restrictions imposed were appropriate and to ensure the least restrictive measures were taken.

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People told us the staff were kind. While relatives praised the staff, they said the staffing levels needed to improve.
- A relative explained the staff met the dementia needs of their loved one. This relative told us their visits to the home were daily. They said "I can see people have a story. You get to know them as people and I can feel that it matters to staff." This relative also explained the one to one support their loved one received from staff. They said "one member of staff reads him poems and I can see they helped him make an anniversary card for tomorrow. It makes a difference. It matters that the staff see him as an individual and that our life [together] matters to them."
- Another relative told us the staff were kind and was "surprised" at the level of kindness shown to their loved one. This relative told us "there is some fantastic committed friendly helpful staff. On the whole [name] is happy."
- Staff told us how they developed trust with people and how they made people feel they mattered. A member of staff said "I don't fly in and out of their bedroom. I ask them how they are feeling. I ask people about their background. Day by day people teach me about what they like. For example, one person likes to be very organised and I try to be organised when I care for her. I try to make her happy."
- We observed the lunchtime meal and in one unit we saw people respond well when a member of staff came to support them. Menus were on tables and a member of staff read them the menu when one person asked about the lunchtime meal. Another member of staff responded calmly when another person gave feedback about the cutlery.
- Staff told us information about people's preferences was documented. A member of staff said, "I ask them [people] about their background. Everybody should have "About me" and "my life" in their care plan or in their pre-admission assessment. In the care plans the action plans should say about people's preferences."
- Cards thanking staff for the care delivered to their relatives were on display in the home.

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

- While a relative praised the staff for their caring approach this relative commented on the inconsistencies with staff acting on their suggestions because they were not relayed to all the staff. They said, "sometimes it's the basics that are frustrating."
- Another relative told us "residents and relative" meetings took place. This relative said "there is always an agenda and some things are carried forward but overall there is actions from the suggestions." Another relative confirmed there were regular meetings and said relative meetings were every three months. This relative said "we get to know about the meeting and we get the minutes from the meetings."

Respecting and promoting people's privacy, dignity and independence

- People told us the staff respected their rights. One person told us how the staff respected their privacy. They said the staff respected their preference to stay in their bedroom with the door shut.
- Care plans gave staff guidance to respect people's rights.
- Staff told us people's consent was gained before they delivered personal care. A member of staff told us "I ask people for their permission to deliver care. I tell people what I am about to do. I explain exactly what I am doing." Another member of staff said people were encouraged to make decisions about their daily lives.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection action was needed to ensure care plans were specific to people and staff clearly recorded the support they provided to people. Improvements had been made at this inspection.

- People's needs were assessed and action plans developed on how to meet the needs identified. For some people in the nursing units the care plans detailed the person's abilities to manage part of their care for themselves and the actions on how staff were to support the person. In the residential unit we found some care plans detailed people's preferences on how the staff were to meet their needs. However, care plans were to the same standard across all units. A member of staff acknowledged some care plans were not person centred and explained that some staff were not involving people in the planning of their care. The registered manager told us staff with strengths in care planning were to be given the lead roles for other staff to have a support developing person centred care.
- There were inconsistencies between the care plan and the evaluation notes for one person. For example, the personal care plan states they were independent with "aspects of their hygiene". On the 4 September 2019 staff had reviewed the care plan and documented in the review notes "requires full assistance from staff to change clothing and assist with personal hygiene. Requires prompting with a shower and supervision." This meant the care plan lacked clarity on how staff were to support the person.

We recommend the provider develop the care planning system to meet current good practice for person centred care plans.

- For some people their life stories were documented. People's life stories were described in some admission documentation. For example, past employment, likes and dislikes.
- One person told us they were unsure if they had a care plan but was certain their relatives were involved in the planning of their care. Relatives told us they were involved in all their family members decisions. These relatives told us they had the appropriate legal powers to make decisions for their family member.
- Staff told us care plans were developed by the seniors and there was an expectation that all staff read care plans.

Meeting people's communication needs

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

impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were assessed. The communication care plan for one person gave staff guidance on how to share information. The staff were to give information in a way that did not "overload" the person. The staff were knowledgeable about how to communicate with people. A member of staff told us they spoke clearly to one person with deteriorating hearing loss. They said for another person with impaired vision the staff placed items within reach and not in areas that cast shadows.

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 home's activities programme was on the notice board and in the lounges. We saw group activities in progress during our inspection days. We saw people enjoy taking part in a quiz. One to one activities were not as regular as group activities. The registered manager told us more regular one to one sessions for people who prefer not to join group activities will take place once the activity coordinator was in post.
- The recently appointed care coordinator told us their vision for activities. This member said "I want to get to know the residents as individuals tap into their experiences skills and memories. I would like to gather information and with residents over time put together posters of personal individual interests, who they were, who I was before I came here."
- We saw sensory lights were being used to help stimulate people. The registered manager said sensory lights were used for one person who looked upwards. There was pet therapy and interactive pets were accessible to people that liked having pets with them.

Improving care quality in response to complaints or concerns

- People told us who they approached with their concerns. Relatives said they contacted the registered manager with concerns and found them approachable. A relative said the registered manager made themselves available to discuss concerns. Staff said the registered manager managed all complaints and they made attempts to resolve minor issues.

End of life care and support

- People with end of life care needs were supported by staff. Relatives praised the staff for the palliative care their relative was receiving.
- End of life care plans gave guidance on the person's wishes, priorities of care and input from external palliative team. The staff we spoke with were knowledgeable about people current palliative circumstances between shifts.

Is the service well-led?

Our findings

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

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

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

- Some improvements were made in relation to medicines since the last inspection. However, the internal audits had not identified the same findings of the inspection. Following the inspection, the provider reviewed their processes for ordering medicines with the supplying pharmacy to ensure the timely supply of people's medicines.
- The quality of the service delivery was assessed. The registered manager was supported by senior managers. There were visits from the quality team and from the regional directors. Quality visits were monthly and reports from the visits were based on observations, review of records and feedback from people. Action plans with timescales were developed where improvements were needed. Although the content of care plan files were reviewed at the quality visit in September 2019, the quality of the care plans were not identified for improvement.
- Improvement plans were linked to the actions required from quality visits and detailed the progress made to each action. For example, introduction of oral health guidance was ongoing and the action to develop a staff training matrix was completed.
- There were systems in place that ensured the staff knew and understood what was expected from them. For example, staff meeting, supervisions and training.
- The registered manager explained the impact their leadership style had on people and staff. The registered manager said "I think that I manage staff the way I would like to be managed. We live the statement that its people's homes. We are honorary members of this family. How we treat people is how we treat our own families. Staff are concerned about staffing and we have increased staffing."

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

- The staff said the values of the organisation centred "on being the best in the country" and their practice promoted a culture that was person centred. However, some staff did not feel valued by the senior management team. A member of staff said, "we are seen as numbers by the organisation." A senior manager said the staff were valued because the staff had access to many rewards and benefits.
- A registered manager was in post. The staff we spoke with said the registered manager was approachable and had introduced improvements. Some staff showed loyalty and care towards the registered manager. A member of staff stated, "she is under pressure [from senior managers]. When we repeated the feedback from staff the registered manager disagreed with their comments that they were under pressure."

- The staff told us how the teams achieved good outcomes for people. A member of staff said "I am blessed we get things done, we work together, we are flexible. We help each other. There are extremely good carers. We are very professional". Another member of staff said "we are a strong team we strive to do our best. The team is variable almost every carer is strong minded to meet the standards."

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

- Relatives told us they were kept informed of events by the staff.
- The providers understood their regulatory requirements to report notifiable incidents to CQC and the local authority. They understood their responsibility to be open and honest when things went wrong.

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

- The views of people and relatives were gathered during meetings held every eight weeks. The registered manager told us the steps being taken to increase attendance to meetings from people and relatives. Suggestions made during the meetings were actioned. For example, activities, community links and housekeeping.
- An external company analysed the quality of care gathered from the views of people and relatives about the service. The registered manager said, "we are in the process of sending surveys out to people for our annual review."

Continuous learning and improving care

- While relatives praised the staff, they said more staff were needed. The staff also said more staff was needed for people to have their care needs delivered. We saw in the survey responses for 2018/2019 where 63% had agreed there was enough staff. This meant that 37% disagreed there were enough staff on duty. The registered manager and the quality assurance lead were confident that the staffing levels were adequate to meet the needs of people. The registered manager said in the response to the report that "we have increased staffing".
- The registered manager said additional support with staff's responsibilities was offered during supportive meetings and where necessary performance was managed.
- Accidents and incidents were analysed for trends and patterns. Risk reducing measures were introduced for people at high risk. For example, the registered nurse allocated a staff member to each corridor, sensor mats were used for people at high risk of falls and hourly checks were carried out for people who need additional monitoring.
- The registered manager said "we look at career progression. Care practitioner roles were created, and staff were supported to build their skills. New staff complete their care certificate and lead roles were to be assigned to staff. For example, staff with a strength in developing care plans were to be given the lead role."

Working in partnership with others

- Social care professionals told us there was a calm atmosphere whenever they went to the home. The staff were always available and had observed good interactions between people and staff. These professionals told us the mix of staff was good and there were good working partnerships. There were open and honest discussions with the registered manager on referrals for admission. These discussions were based on the staff's abilities to meet people's needs.
- The registered manager said there had been partnership working during the winter months. A number of beds were allocated for people who were medically fit to leave hospital which meant there was support from staff with relieving pressure on hospital discharge. The registered manager told us "we have developed positive relationships with the mental health team and hospital on how much information can be shared"

under GDPR."

- The registered manager described the contact the staff had with community teams. The registered manager said there were regular visits from health care professionals who offered advice and training to staff. For example, district, tissue and palliative nurses.
- The registered manager had joined a number of projects to support people's ongoing healthcare needs. For example, National Early Warning Scores (NEWS) which improves the detection and response to deterioration in the health of the person.
- People had access to community clubs such as the WI. The registered manager said "people are going out to community services and members of the public tells us about community activities. This meant the people in the home were seen as part of the community."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicine systems were not safely managed. People medicines were not administered as prescribed