Care Solutions (East Anglia) Limited

Ramsey Step Down and Care Centre

Inspection report

Ramsey Road
Harwich
CO12 5EP

Tel: 07794985171

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ramsey Step Down and Care Centre is a residential care home providing personal and nursing care for up to 37 people. The service was originally set up to support hospital discharges during the COVID-19 pandemic. It continues to provide a step down service for patients discharged from hospital and requiring continuing nursing care. Some people chose to remain at the service beyond their planned short stay, while other people were receiving end of life care. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
The registered manager and provider had not put in place effective systems to protect people from risk and ensure they receive good quality care. Improvements were needed to formal systems throughout the service, particularly in the oversight of clinical care and quality checks which had not picked up the concerns we found during our inspection.

Care plans and risk assessments lacked detail and did not provide enough information about people's current and changing needs to assist the registered manager to plan care and decide on staffing levels. Staff recorded the support they provided; however, the information was not effectively analysed to check for gaps or trends.

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. However, the policies and systems in the service did not support the registered provider to meet their legal requirements when supporting people who lacked capacity to make decisions about their care.

People received their medicines as required, though medicine care plans lacked detail. There were enough safely recruited staff to keep people safe. Systems to safeguard people from abuse were improving, however greater transparency was required during internal investigations and complaint management. The registered manager had measures in place to minimise the risk of infection.

Staff were knowledgeable about people's needs and provided personalised care. They worked well with other agencies to meet people's needs in a holistic manner. People had support to eat and drink in line with their preferences and health needs. The registered manager was enhancing the environment to meet the needs of the people living at the service.

There was a positive culture at the service. Care was compassionate and respectful. People and their representatives were positive about the culture of the service and told us people achieved good outcomes.

Staff communicated well with people and their representatives to ensure they were involved in making decisions about care. People were supported to remain active and stimulated. Staff encouraged people to maintain their skills, enabling them to return home where appropriate. People received compassionate care at end of life from a team of committed staff supported by external professionals.

Stakeholders told us Ramsey Step Down and Care Centre provides a strategically important and flexible service which supports hospital discharge at a time of high demand for health and social care services. In 2021, the CQC report, "Enabling innovation and adoption in health and social care: Developing a shared view" highlighted one of the principles of innovation as "Focus on outcomes and impact." We found the provider reflected this innovative approach and achieved positive impact and outcomes. Following our inspection, the provider responded positively to address the concerns we had raised around risk management and care planning, whilst still retaining a commitment to innovation.

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

Rating at last inspection
This service was registered with us on 4 January 2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service, which included concerns received about the culture and management. A decision was made for us to carry out the first inspection of the new service and also look into the concerns raised.

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
At this inspection we have identified breaches in relation to safe care and treatment, need for consent and governance arrangements. Please see the action we have told the provider to take at the end of this report.

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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Ramsey Step Down and Care Centre

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.

Inspection team
The inspection team consisted of five inspectors and an Expert by Experience who made phone calls to people's family and representatives. 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
Ramsey Step Down and Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ramsey Step Down and Care Centre is a care home with nursing care. 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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
We spoke with six people who used the service about their experience of the care provided. We spoke with the registered manager, the general manager, the administrator, the clinical lead, two nurses, the chef and five care staff. We met with four family members and three external professionals who were visiting the service.

We reviewed five people's care records and medication administration records. We looked at three staff files. We also looked at a variety of records relating to the management of the service and quality assurance arrangements.

After the visit to the service
We had phone contact with eight family members for feedback about the service. We had email contact with six staff. We continued to seek clarification from the provider to validate evidence found and to gain assurances about some of the concerns we found during our visit to the service. We had email or phone contact with five professionals who had contact with the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Assessments of people's needs, and risk had not been recorded for people on their arrival at the service. This included risk assessments in relation to skin breakdown, diabetes, dementia, falls, pain and choking. There was a reliance on the information from professionals involved in moving people to the service.
• Care plans did not provide sufficiently detailed information and guidance to staff to ensure they could support people safely. For example, a person was diabetic and there was no personalised care plan with guidance on how low or high blood sugars affected them or how to recognise signs they were becoming unwell and what action was required.
• The registered manager had not ensured there were effective systems to review people's needs and risks and update care plans as their circumstances changed. A person had changed from receiving food via a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube to having a normal diet. Their care plan had not been amended to outline potential risks and monitoring requirements, which put them at risk of receiving unsafe care.
• There was a variety of equipment such as mobility aids at the service, however there was not an effective system to ensure the equipment was safely maintained and serviced. The risk was reduced when people were at the service for a brief time, however the registered manager had not set up monitoring systems when people extended their stay at the service.
• There was also a room used for rehabilitation by external professionals, which housed a variety of equipment. The room was unlocked and could be accessed by people at the service. The registered manager was not able to assure us who was responsible for servicing this equipment. On the day of the inspection the registered manger confirmed the door would now remain locked. After our visit we received information confirming the external agency was responsible for servicing the equipment.
• There were plans for what to do in the event of a fire however individual Personal Emergency Evacuation Plans (PEEPS) were not in place. This lack of information about the personalised support people needed in the event of an emergency put people at risk. On the first day of our inspection senior staff started putting these plans in place.

We found no evidence people had been harmed. However, systems were either not in place or robust enough to manage and mitigate risk. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Despite the lack of systems, staff described how they supported people safely. A nurse told us how they carried out daily checks of a person's sugar levels and the actions they took when they were concerned about changes in the levels.

• Families described how they had been involved in setting up safe care arrangements. "We took in some clippers for our relative's hair, and staff put them in the salon for safety" and "Staff have communicated with us regarding the moving and handling of [Person] safely."

Systems and processes to safeguard people from the risk of abuse
• Prior to our inspection a number of concerns were raised to CQC and the local authority about people's safety. Senior staff had worked well with professionals to investigate the concerns and take action. A professional told us, "They are quite good, they raise a safeguard or an unwitnessed fall, at first they didn't but they responded well to feedback and are now doing this better."
• A significant number of concerns which had been raised recently were not upheld. However, there was scope to improve internal investigations when concerns were raised about family members. The registered manager acknowledged there could be a conflict to interest in current investigation processes and assured us they would ensure greater transparency in future investigations.
• The registered manager did not have effective systems to examine trends in safeguarding concerns over time. It was not always easy for them to pull information together for investigations. They agreed to address this as part of the overall improvements in their management processes.

Staffing and recruitment
• The registered manager did not use a formal system to ensure there were enough staff on duty to meet people's needs. There was not always a trained nurse on duty. The lack of detail in care plans and oversight tools meant the provider could not demonstrate how they considered people's current needs when calculating staffing numbers, in particular qualified nursing staff.
• A student nurse was employed as clinical lead, overseeing clinical care at the service. They were supported by registered nurses. However, the registered manager was not able to demonstrate they had systems in place to ensure the staff team on duty at any time had the required mix of competency, qualification and experience to meet people's needs. Immediately after the inspection the registered manager improved their systems and appointed a new clinical lead to assure themselves competency checks were completed by staff with the necessary qualification.
• We found minimal impact from the lack of systems to calculate staffing levels. On the day of our inspection we found there were enough staff to meet people's needs. This was confirmed by people and their representatives. A relative told us, "There always seem to be someone around to keep [Person] safe" and "I think that there is enough staff and there seem to be same staff around."
• Appropriate arrangements were in place to ensure the right staff were employed at the service. Relevant checks were carried out before a new member of staff started working at the service. Staff described competency checks which took place to ensure staff had the necessary skills to support people safely. Staffing files were not always well-ordered, reflecting the lack of management systems, however, senior staff had already started to address this prior to our inspection.

Using medicines safely
• The service had an electronic system to monitor the administration of medicines, which immediately flagged up any gaps and helped ensure people had support to take their medicines, as prescribed. A relative told us, "[Person] does have medication and staff make sure that they take them."
• Care plans did not provide enough information and guidance for staff about prescribed medicines on their purpose and any signs to be aware of in relation to side effects. No protocols were in place for people prescribed medicines to be taken 'as and when required' [PRN]. Immediately after the inspection, senior staff developed a template for PRN protocols to be implemented. They also assured us they would improve guidance to staff, in line with overall improvements in care planning.
• Due to the short-term nature of some of the stays at the service. timely supply of some medicines was an issue. Staff had advocated and negotiated for people to ensure there was no impact, however it remained a

concern. The registered manager was in discussion with health representatives to resolve this.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections. A relative told us, "During covid they managed quite well. We had to be tested before we went or do it at the door and wait for a negative result. We used sanitiser, wore masks 24/7."
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. A professional told us, "The home is clean and has no unpleasant odours."
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
• When the service was initially set up, there was a focus on short-term clinical care. Visiting times were limited to enable rehabilitation and clinics to take place in the morning. Some families told us they found the visiting times too restrictive. Formal visiting times had not been adjusted as people chose to stay longer at the service. The registered manager was reviewing visiting arrangements to support people to maintain relationships and enable visitors to feel welcome.
• Staff and families told us the set times were flexible by negotiation. Relatives told us "A family member turned up one weekend at the service and were let in" and "It is like an extension of family; you are always welcome."

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.

This is the first inspection for this newly registered service. This key question has been rated 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.
• Most of the people at the service had capacity to make decisions. Care plans did not provide adequate information about supporting the people who lacked capacity. The clinical lead informed us mental capacity assessments were the responsibility of the placing professionals.
• A person's care plan stated "they do not understand" under the section covering capacity. There was no information about how this had been assessment or what areas of capacity this referred to. Lack of a full understanding and oversight of capacity assessments put people at risk of unlawful support and restriction.
• There were no formal measures to reviews of any Mental Capacity Assessments which were in place on admission to the service. This was particularly a concern where people chose to extend their stay at the service.

The registered manager failed do demonstrate they were acting in line with their responsibilities under the Mental Capacity Act 2005. This was a breach of Regulation 11 [Need for consent] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Despite the lack of processes in relation to the MCA, we found staff had a good understanding of capacity on day-to-day basis. We observed staff discussing the right of a person with capacity to choose to eat a biscuit. The member of staff explained, "We offer advice but in the end the person has the capacity to make their own decisions." A relative told us, "[Person] can't make informed decisions; staff explain things to help them keep safe."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans did not have enough details about people's assessed needs and did not provide staff with adequate guidance about specific conditions such as dementia. However, staff had communicated with people, families and professionals to get up-to-date information and were able to describe how they met people's needs. A relative said, "I was involved in the assessment of his needs; I had an input." A health professional told us, "They ask the right questions about people's needs."
• Senior staff had realised they needed to improve their care planning prior to our inspection. They had revised one care plan for a person but had not yet rolled the new format out. A professional told us, "They have sent the draft care plan. It's really good, one of the best I have seen."
• Despite our concerns regarding the care planning process, we found positive evidence about the delivery of care. Although care plans did not adequately outline aims and tasks in relation to rehabilitation from hospital, feedback in this area was overwhelmingly positive. A person told us, "I do exercises with the staff. I was weak in the arms, but physio comes in on Wednesdays and gave me more exercises for my arms and now my arms feel stronger. I am going home soon." A relative said, "My family member arrived with lesions and sores, they have now all gone since being there."

Staff support: induction, training, skills and experience
• Although there was a lack of management oversight of staff care and nursing skills, we found individual staff to be skilled and competent. We observed people receiving support with hoisting and staff were skilful and highly attentive to people's needs. Relatives spoke positively about staff skills. They told us, "I feel that the staff have the training and understand [person's] needs" and "Most definitely they have the skills to look after [person]."
• Staff completed a detailed induction. Staff who were new to care completed The Care Certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
• Staff attended online and in-person training. The registered manager was committed to developing staff skills. They had funded staff to do additional training and were regularly sourcing new courses as the service developed. Senior staff attended specialist courses such as wound care and food preparation to enable them to lead staff in this area.
• In the absence of adequate records, verbal communication was key to ensuring staff knew how to support people at the service. A member of staff told us, "If you're on a shift and there's something to share, they'll get everyone in, and do another meeting for the night staff too."

Supporting people to eat and drink enough to maintain a balanced diet
• People received the necessary support to eat and drink in line with their preferences. However, care plans did not always provide sufficiently detailed guidance to staff in this area. • Catering staff had been trained to on how to offer choice and support people in line with their needs, for example they were able to explain to us how they prepared pureed food. A professional told us, "The food is lovely, even the pureed diet. It's very fresh food."
• Relatives described how personalised support with eating and drinking had enhanced their family member's wellbeing and was key to them achieving positive outcomes. They told us "When [person] is off eating, staff tempt them with jellies, yoghurts and ice cream" and "[Person] is enjoying the food and eating much better. They are looking 10yrs younger." People enjoyed picking vegetables and salad from the garden for their meals. This supported their wellbeing in terms of exercise, healthy eating and involvement in food choices.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Some external agencies did not have systems to support the service in delivering effective care, such as

enabling all people on short-term placements to access GP services. The registered manager had not set up formal agreements before the service opened to ensure people had access to GP services. However, they were working hard with partners to address this issue.
• Staff were passionate about advocating for people to ensure they had access to a variety of professionals. A relative told us, "When [person] was not feeling good, within an hour the GP was here." The service was supported well by varied healthcare professionals such as Speech and Language Therapists (SALT), physio and the local hospice.
• An advanced practitioner visited weekly from the local surgery. We observed their visit and saw they supported staff to meet people's health needs, such as agreeing a plan to encourage a person who was refusing to take their medicines.
• Feedback from professionals directly linked to the service was positive. A health professional told us, "I am always greeted by a team member who knows what is going on. They contact me and are good at keeping in touch. They follow instructions well and they know people really well."

Adapting service, design, decoration to meet people's needs
• Some of the environment had an institutionalised feel, reflecting the initial model of short-term hospital discharges. Recently the registered manager had started to adapt the design to reflect people's choice to remain living at the service, such as changing the layout of the dining area.
• Individual rooms were more personalised. A relative told us, "[Person's] room and environment is nice and feels homely."
• The design of the service enabled staff to provide care in the least restrictive manner possible. There were no internal door codes along the corridors so that people could walk freely within the communal areas. People had a say in the design of the garden and raised flower beds had recently been turned over to vegetables which were used during mealtimes.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. 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
• Before our inspection we had concerns raised about the culture at the service. However, we found no evidence to support these concerns. People and their representatives all described a caring atmosphere.
• Relatives spoke warmly about how staff supported their family members. They said, "Staff are kind and caring, [Person) was scared, Staff befriended them and made them feel safe by talking about upcoming events" and "When I phone up, they sound gentle and caring, I have never had the impression that it's just a job for the staff."
• This feedback was in line with our observations throughout our inspection. People were treated with kindness and compassion in their day-to-day care and support. Management and staff made people to feel that they mattered and included.
• During our visit we asked a member of staff to find us some information. On the way to the office, a person approached the member of staff and said they couldn't not eat as they were so anxious. The member of staff courteously asked us if they could prioritise the person and offered reassurance. We later saw the person eating a banana and laughing with other people in the lounge. This example demonstrated how staff focused on the wellbeing of the people they supported.
• The provider aimed to create a family-style environment. A senior member of staff told us, "All staff are very caring and compassionate towards our service users. They are all treated as our extended family."
• Staff knew the people they supported, including their preferences and personal backgrounds. This helped them build good relationships with people and their families. Relatives told us they appreciated having consistent staff. A relative told us, "I do think that they make sure that [person] sees the same familiar faces."

• Despite the gaps in systems and record keeping, the provider demonstrated they had developed a caring service where people's needs and wellbeing were their priority. Their openness to improve the service highlighted their commitment to providing person-centred care.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
• Staff put people at the centre of the service and involved them and their representatives in developing the care they received. Throughout our visit we observed staff communicating with people and explaining the care they were providing.
• Staff supported people to make decisions about their care and used encouragement to enhance their quality of life. They always asked before carrying out any tasks such as assistance to go to the toilet. A relative told us, "[Person] can make decisions to a certain degree but staff would encourage them to make decisions like shaving and tidying their room."

• We observed dignified, respectful care throughout our visit. Staff knocked prior to entering people's bedrooms. Relatives told us they appreciated the staff efforts to maintain people's dignified appearance. Relatives said, "They do [person's] hair and nails, and they look clean and tidy when we visit."
• We had numerous examples where relatives felt staff had gone over and above in their support. A relative said, "The hospital sent [person] here with nothing. I was travelling and staff said not to worry. They provided with toiletries, continence pads and nightwear. Who would do that? They were so caring and helpful."
• A professional described an example of highly compassionate care. Senior staff had spent a long time getting to know a person who was distressed and learning about their past. They found a task for the person to become involved in. The professional told us, "[Person] is now supporting other people at the service. They feel part of something and that they are wanted."
• Staff encouraged people's independence, enabling them to regain and maintain their skills. We observed a person help set and clear the tables. A relative told us, "They encourage [person] to do things for themselves, walk about on their own, that sort of thing."

Good

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

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

• Despite paper care records lacking detail, we found the care people received was person-centred and adapted to peoples' changing needs. A member of staff told us, "I learn about new admissions from attending daily handover meetings. I speak to the nurse in charge or manager about new arrivals or if anyone's condition has changed." A relative described how they had been involved in discussions where all involved agreed on a change in a person's diet.

• People were treated as individuals. Staff knew about their preferences and dislikes and this was reflected in the support they provided. A relative told us, "When [person] wanted jellied eels, they went out and got them".

• Communication and involvement with relatives and representatives was person-centred, despite the visiting arrangements outlined in the safe section of this report. Relatives told us, "On the day the hospital discharge was happening they promised to ring us. They did and they let us visit even though it was late, they have showed us the same respect since" and "I can phone anytime, and they would call if any change in my family member's health."

• People were encouraged to stay occupied and engaged. We had positive feedback about how well staff supported people to keep them active. Throughout the day we observed staff interacting with people. Staff had sought advice from a health professional about how to develop stimulating activities. This is an example of best practice and engagement, which demonstrated a responsive approach to promoting people's wellbeing.

• Staff organised events, weekly trips out and celebrated special days such as birthdays. Relatives told us, "They are now doing more activities like gardening and taking them out" and "[Person] has the hairdresser come and went out to the little local cinema to see Seven Brides for Seven Brothers. They loved it. They play bingo and receive prizes."

Improving care quality in response to complaints or concerns

• Two relatives told us they were not sure how to raise formal concerns, though they felt able to approach senior staff. There was room to review and enhance communication around complaint processes as part of the overall improvement in formal structures discussed in the well-led section of this report.

• The remainder of the relatives and representatives told us they had very few complaints and when they had raised informal concerns these had been dealt with well. For example, a relative described how their family members care had been tweaked after a meeting with senior staff.

End of life care and support

• There was room for improvement in the care plans for people receiving end of life care, as described in the effective section of this report. However, there was minimum impact on the care people received and we found examples of highly personalised being provided to people at the end of their lives.
• The registered manager described how they had accommodated the family of a person who had died at the service. They told us, "We recently had 15 people from one family visiting and we handed them the staff room and supplied teas and coffees, so they were able to come and go."
• People had access to support from specialist palliative care professionals. A relative described the agencies involved with their family member's care who worked well together to ensure they received holistic end of life care. We observed a nurse from local hospice visiting a person at the end of their life and offering advice and support to the team and the individual. A professional told us, "I loved how they were with a person when providing end of life care. It's really nice."

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• There were management systems in place to measure the quality of care, however they did not adequately pick up the concerns found during our inspection. A care plan audit in July 2022 stated that, "All care plans are completed, and care plans met the current need." However, we found that the care plans were incomplete and did not always reflect people's current needs. This lack of oversight put people at risk of receiving unsafe care.

• The provider's fire audits had failed to identify the lack of Personal Emergency Evacuation Plans. They had therefore not ensured staff had the necessary information about the level of assistance each person needed.

• The registered manager did not have effective oversight of Mental Capacity Assessments or 'best interest' decisions completed for each person, including those carried out by external health professionals. There was a lack of systems to demonstrate people were not being deprived of their liberty without authorisation.

• Roles and responsibilities were not clearly defined, in particular the responsibility for clinical oversight. At the time of the inspection the clinical lead was a student nurse. The registered manager was not able to demonstrate how they assured themselves tasks were being completed to the required standards. A relative told us it was not always clear which member of staff representatives should speak to, depending on the care being provided, such as end of life or short-term rehabilitation.

• Weights were measured on admission and weekly and a member of staff described how they were checked. However, the registered manager was not able to demonstrate how they knew any deterioration in relation to nutritional needs or weight loss was consistently monitored and acted upon.

• The registered manager lacked robust systems to demonstrate how there was sufficient staffing to meet people's needs. Logs of people's clinical needs were based on their needs on admission. This was particularly a concern where people chose to remain at the service in the longer term, as this system was not based on their current needs.

• Management and staff used a digital care planning system with which they were not fully familiar. Senior staff pulled some information off the systems such as training details for the inspection but were not able to demonstrate the systems were being fully utilised by the registered manager to oversee the service.

• Relevant legal requirements relating to regulation and registration were not understood, including the submission of statutory notifications regarding expected deaths.

The provider's quality assurance and governance arrangements were not effective. This was a breach of

Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Immediately after the inspection the registered manager moved an existing registered nurse to the clinical lead role. They also met with the local authority for advice on setting up a system to match staffing to people's level of needs.
• The provider already notified other agencies as required and told us the failure to notify CQC fully was a misunderstanding. Immediately after our inspection they started notifying as required.
• Despite the lack of key systems, in particular in relation to clinical oversight, there were some effective quality assurance systems in place. For example, there were effective checks around infection prevention and control.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Despite the concerns described above, we found people achieved good outcomes at the service. Professionals told us, "People are very happy here. A person I was working with did a 360 degree improvement" and "The person I work with has flourished."
• Relatives also told us people achieved good outcomes. A relative told us, "Since [person] has been here it has been such a transformation. Their mobility, eating, happiness and health. For us as a family it really is lovely to see" and "[Person] is so much better and more confident than before they went into the home."
• People's views were central, and the registered manager engaged well with people to develop the service in line with them. For example, the improvements in the garden and the changes in the dining and living areas were in response to consultation with people.
• Prior to the inspection we had received concerns about poor management culture. Every member of staff we had contact with was positive about the management team. Comments included, "I have worked in care before, and I think they manage very well", "The management are approachable, they know what is happening there" and "Nothing is too much trouble. I am happy with the way the home is managed and they are open to suggestions."
• The provider invested in staff in a holistic way. They had purchased electric bikes as they found staff were anxious with the increase in fuel costs. A staff member told us, "I expressed interest to go and complete my training. My managers kindly helped me, and now I am enrolled to do my studies."

Continuous learning and improving care; Working in partnership with others
• The registered manager had an innovative approach and was continually looking to develop the service in response to local need. They had set up during the COVID-19 pandemic to provide short-term placements to facilitate hospital discharges. It remains strategically important and plays a key part in supporting local people to achieve good outcomes through enabling hospital discharges.
• However, the service model had become confused. In addition to short-term hospital discharges, people were also choosing to stay at the service for longer. The service had also developed as an end of life care service, with the support of the local hospice. The registered manager acknowledged this lack of focus was in part at the root of the lack of formal systems and it was vital they continued to work with local partners to agree how the service should develop in the future.
• The service worked in partnership with health and social care partners to develop the service. However, this had its challenges. The registered manager spent a lot of time problem solving, for example around GP cover and access to medicines. This meant they had not always focused on setting up some of the fundamental structures in the organisation.
• Professionals who visited the service regularly were overwhelmingly positive about the service. A professional told us, "Partnership working. That's what It's about - we need providers to be like this."

Stakeholders also praised this approach, "Ramsey is keen to work with system partners to support where able and always to look at innovation in practice."

• The service was a family run business with close family members providing the management and leadership of the service. Prior to the inspection, former staff told us they did not always feel they were able to raise concerns. Current staff told us they felt able to speak openly. The registered manager admitted it was not always easy to take criticism, especially against family members and they had not always reacted in a positive way in the past. They were anxious to address this to ensure the service was transparent and better able to learn from feedback and mistakes.

• The registered manager used informal systems to involve staff and drive improvements. They told us, "When we had a safeguarding, we called everyone and shared the complaint and said what we were going to do going forward as part of the risk management plan." The registered manager had already been speaking with providers of care systems, having recognised they needed to improve their processes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager failed do demonstrate they were acting in line with their responsibilities under the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence people had been harmed. However, systems were either not in place or robust enough to manage and mitigate risk.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's quality assurance and governance arrangements were not effective.

The enforcement action we took:

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