Ashberry Healthcare Limited

Moorhouse Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Moorhouse Nursing Home is registered to provide accommodation for up to thirty-six older people who require residential or nursing care. The rooms are arranged over three floors. There are stair lifts and a lift to each floor. On the ground floor there is a large dining room, two lounges and further sitting areas. The home also has its own gardens. At the time of our inspection there were 21 people were living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was at the home during the time of our inspection.

We last carried out a comprehensive inspection of Moorhouse Nursing Home in December 2016 and a focused inspection in February 2017 where we found the registered provider was in breach of regulations. These related to staffing levels; staff had not received support, training, professional development and supervision in order that they could fulfil their duties and responsibilities. Following this inspection the registered provider sent us an action plan of how they would address these issues.

The inspection took place on 13 March 2018 and was unannounced. During this inspection we found that the concerns raised at our previous inspection had been dealt with, but we did identify new concerns about record keeping.

Not all records included all full guidance to help ensure that staff were able to deliver the care people needed. Accidents and incidents were recorded but not all had an analysis of why accidents or incidents had occurred or what action could be taken to prevent further accidents.

There were enough staff to meet the needs of the people but the deployment of staff requires monitoring, especially at weekends. Robust recruitment procedures were completed to ensure staff were safe to work at the service. People felt safe living at the home. Staff understood their responsibilities around protecting people from harm. The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk. Infection control processes were in lace that helped to reduce the risk of infection. People received their medicines as prescribed by their GP.

Staff received appropriate training and had opportunities to meet with their line manager regularly that helped them to provide effective care to people. Where there were restrictions in place, staff had followed the legal requirements to make sure that this was done in the person's best interest. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that decisions were made in the least restrictive way. People's nutritional needs were assessed and individual dietary needs were met. People could choose what they ate.
People had involvement from external healthcare professionals and staff supported them to remain healthy. The environment was suitable for people living with dementia.

People's care and support was delivered in line with their care plans. People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them. People were supported with their religious beliefs and were able to practice their faith. Visitors were welcomed at the home and people could meet with them in the privacy of their bedrooms.

A variety of activities were available for people to take part both internally and externally on trips and excursions to places that interested them. Documentation that enabled staff to support people and to record the care they had received was up to date and reviewed on a regular basis. Staff were knowledgeable about people's needs and had received training that helped to attend to the assessed needs. People would receive end of life care that was in line with their needs and preferences. Care plans included people's requests about their end of life wishes that included if they wanted to remain at the home or be admitted to hospital.

Complaints were addressed within the stated timescales to the satisfaction of complainants. A complaints procedure was available to people, relatives and visitors.

The provider and staff undertook quality assurance audits to monitor the standard of service provided to people. An action plan had been produced and followed for any issues identified. People, their relatives and other associated professionals had been asked for their views about the service through surveys and resident and relatives meetings.

The interruption to people's care in the case of an emergency would be minimised. The provider had a Business Continuity Plan that provided details of how staff would manage the home in the event of adverse incidents such as fire, flood or loss of gas or electricity.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to meet the needs of the people but the deployment of staff required continuous monitoring. Appropriate checks were completed to ensure staff were safe to work at the service.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm.

The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk.

People received their medicines at the correct time and when they needed them.

Infection control processes were robust.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and had opportunities to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People's nutritional needs were assessed and individual dietary needs were met. People could choose what they ate.

People had involvement from external healthcare professionals and staff supported them to remain healthy.

The environment was suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in line with their care plans.
People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

People were supported with their religious beliefs and were able to practice their faith.

Visitors were welcomed at the home and people could meet with them in the privacy of their bedrooms.

Is the service responsive?

Good

The service was responsive.

People had person centred care plans that they and their relatives had helped to write. Where people's needs changed staff ensured they received the correct level of support.

A variety of activities that interested people were available for them to take part in.

Information about how to make a complaint was available for people and their relatives.

People would receive end of life care that was in line with their needs and preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Not all records maintained by the provider were fully completed in relation to the care of people.

People and their relatives had opportunities to give their views about the service.

Staff felt well supported by the manager.

Staff met regularly to discuss people's needs, which ensured they provided care in a consistent way.

The provider had implemented effective systems of quality monitoring and auditing.

The provider was aware of their responsibilities in regard to sending Notifications about significant events to the Care Quality Commission.	

Moorhouse Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Moorhouse Nursing Home 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. Moorhouse is registered to provide accommodation for persons who require nursing or personal care for up to 36 people. There were 21 people living at the service at the time of our inspection.

This inspection took place on 13 March 2018 and was unannounced.

The inspection team consisted of two inspectors, one nurse specialist who was experienced in care and support for elderly people and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed to see if we would need to focus on any particular areas at the home.

We spoke with nine people who lived at the home, seven relatives, the lead nurse and nine members of staff. We also spoke with the registered manager who was present throughout the day. We observed how staff

cared for people, and worked together. We also reviewed care plans and other records within the service. These included nine care plans and associated records, six medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

Good

Our findings

At our previous focus inspection in February 2017 the service was in breach of Regulation 18 that there were not always sufficient numbers of staff on duty at the service. The provider sent us an action plan explaining how they would address this. During this inspection we found that the numbers of staff on duty had improved, however, the deployment of staff requires further action from the provider.

People's perception was that there were times when they did not feel there were enough staff on duty, particularly at weekends. One person told us, "There are times when there are not enough staff and I can ring the bell and wait a long time to be helped. This often happens after meal times or when staff change shift." A family member also said that they had noticed that they often seemed short staffed at the weekend and their family member had told them that they had to wait a long time for the call bell to be answered at night, however, they could not state the length of time they had to wait. We looked at the response times for answering call bell for the last two months. We noted that they were usually responded to between three and eight minutes. The registered manager told us that the policy allowed up to ten minutes for call bells to be responded to and that she was monitoring these. This would indicate that there were enough staff to meet people's needs.

The registered manager told us that the staffing at the service for 21 people consisted of one registered nurse (RN) and four care staff throughout the day. In addition to this there was the registered manager and deputy, both who are RNs and supernumerary to the duty rota, and at least one activity coordinator. There was also a team of domestic and kitchen staff. The registered manager told us that this was the same staffing at weekends with the exception that the registered manager and deputy worked alternative weekend days. The night time was covered by one RN and two care staff. These numbers were confirmed during discussions with staff and the viewing of the duty rotas for four weeks.

Staff told us that there was sufficient staff on duty at all times. One member of staff told us, "I feel there are enough staff, the staffing levels have increased and improved." They told us the mornings were busy but in the afternoon they usually had time to sit and chat to people. Another member of staff told us, "There are always enough staff but we do use a lot of agency staff." People told us that the main carers were good, but that the agency staff were not so good. One person told us, "I am not so confident with the agency staff." We noted on the duty rota that there were at least two agency staff covering the day and night duties since the end of February and March 2018. A visiting healthcare professional told us that there were always enough staff whenever they visited the service. They told us, "The staff team seem to be much more stable. There is less use of agency staff and the communication with staff was much better."

The registered manager told us that they were actively recruiting staff and that there had been a decrease in the number of agency staff used. They told us that all agency staff undertook a formal induction to the service prior to commencing their duties. The staffing numbers were being monitored by the registered manager throughout 24 hours with unannounced visits at night times and weekends. The registered manager was continuing to monitor the deployment of staff, especially at weekends and records of these were forwarded to us.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed. All the required documentation, including a full employment history, references and Disclosure and Barring Service (DBS) checks had been obtained for new staff. The DBS helps providers ensure only suitable people are employed in health and social care services.

People were protected from the risk of abuse. People told us that they felt safe with the regular staff that looked after them. People commented that the regular staff were generally good and they felt safe with them. One person told us, "Yes, I think I am safe."

Staff had a clear understanding of their responsibilities in relation to safeguarding people. One staff member told us, "It is our priority to keep all people safe. If I had any concerns I would talk to the nurse in charge or the manager." Staff were aware of the different types of abuse and the external agencies they could contact such as the local Adult Services Safeguarding Team and the CQC. Staff told us that they had safeguarding training every year and that this included whistle blowing. This was confirmed in staff training records that were provided to us.

People's safety had been assessed and risk assessments related to their health and support needs had been put in place. These included risks in relation to falls, mobility, and nutrition and skin integrity. We noted that these had been regularly reviewed. There was information to guide staff about to how to minimise some risks. For example, for one person who was at risk of falls the guidance said that staff must ensure that they used their wheeled walking frame and to encourage them to only walk short distances.

Medicines were administered, recorded and stored safely. People received their medicines when required and as they were prescribed by their GP. The service uses a Proactive Care System (PCS) e-Mar system. Electronic medicine administration records (MAR) charts had photographs of people using the service, date of birth, allergies and their general practitioner (GP) details. This meant that staff who were unfamiliar with people, for example agency staff, were assisted to identify people they were administering medicines to. We observed the lunchtime medicine round which was being carried out by a permanent member of staff. During this round we saw that the staff checked people had swallowed their medicines prior to signing the MAR chart. The MAR charts had been consistently signed in the past and no omissions were noted. "PRN "(as required) medication alerts were automatically generated by the PCS system. There was no pain assessment tool to assess if people were in pain and the clinical leader said she was looking into implementing an appropriate form for this.

Medicines were stored safely in locked trolleys. The trolleys were organised with people's medicines stored in an orderly manner. Bottled medication and creams had open dates written on them to ensure they were still within safe use dates. The temperature of the refrigerator was checked daily and monitored, with clear guidance for staff on what to do if the temperature went out of the medicine manufacturers range.

People were protected against the spread of infection within the service. People lived in an environment that was clean and hygienic. All areas of the service were very clean and tidy. Personal protective equipment (PPE), such as aprons and gloves, were readily available to staff. Staff told us that they had received training

in regard to infection control. Staff told us that they undertook this training every year and were able to describe what they had learnt for this. For example, hand washing and the importance of changing PPE for each person you support with their personal care. Regular audits were undertaken to monitor and control the risk of infection. People confirmed that the service was always clean and staff wore gloves and aprons when required.

When people had accidents or incidents these were recorded and monitored by the registered manager. Staff told us that these were discussed with the staff team, and when necessary, with other agencies so that lessons could be learnt action plans to help prevent a repeat could be put in place.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Each person had a personal emergency evacuation procedure (PEEPs). These provided staff with the knowledge they needed to safely support each person in the event of a fire and how they should be helped to evacuate the service. There was an emergency procedure at the home that provided guidance to staff on what to do if the service became unusable due to loss of electricity, gas failure, fire or floods. It included the emergency contact details of the provider, external services that could be required and the details of where people could be evacuated to. Staff were aware of the procedures to be followed.

Good

Our findings

At our previous comprehensive inspection in December 2016 we identified a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014. Staff had not received training about dementia and regular supervisions and appraisals had not been taking place. During this inspection we found that the concerns had been addressed.

People were supported by staff who had regular supervisions (one-to-ones) with their line manager. Staff told us that they received supervision every two months. Staff told us that they discuss their roles, the people they worked with and identified their training needs.

People received effective care from staff who had the skills, knowledge and understanding needed to carry out their roles. People told us that they thought the staff were well trained to support them with the care they required. One person told us, "They've been doing this a long time; they just get on with it." Staff told us that they had undertaken all the mandatory training as required and this was confirmed in the training records provided to us. Other training staff had undertaken included dementia that had included e- learning and face to face training, positive behaviour support, pressure care and end of life care. Staff were able to explain what they understood about dementia. One member of staff told us," We always comply with their needs and wants and also that if people didn't want to do something, not to force it." Another member of staff told us, "We must always make eye contact with people when we talk to them, be patient and believe in what they have to say even if it is not real." A relative told us, "When [family member] was admitted a year ago I was told that they wouldn't last more than a couple of weeks, yet here they are, that must show that they are looking after her well. I think they [staff] are well- trained."

People's needs and choices were assessed and care, treatment and support was delivered in line with current legislation. People's needs had been assessed before they moved into the home to ensure staff could provide the care they needed. The provider told us in their PIR that potential people were assessed prior to moving into the service to ensure that their needs could be met and we found this to be the case. Records maintained showed that people and their relatives had been involved in the initial assessment of their needs before they moved into the home.

People were supported to ensure they had enough to eat and drink to keep them healthy. People told us that the meals provided were good. One person told us, "The food is very good here." Another person told us, "The chef makes super sandwiches and the food is excellent." We observed the lunch time during our visit. We heard two people talking to each other about how good the food was. One person stated, "The

food is very good but they give me too much." The other person commented, "Why don't you tell the staff" to which the first person replied "I mean to every time I have a meal but I keep forgetting." We passed this on to the registered manager who told us that this would be addressed.

We observed lunch time in the dining room. Staff asked people if they would like a clothes protector and those who said "No" were not provided with one. Staff were available in the dining room to provide support to people as and when required. Relatives were also complimentary about the food provided at the service. One relative told us, "The food is really good."

People's individual dietary needs were met, such as soft diets for people who had difficulty swallowing. For example, one person had an assessment from the dietician in their records that recommended staff try to ensure that the person ate 5100 calories per day to increase their weight. A nutrition care plan showed that the person was on a food and fluid chart that was completed accurately each day. Records showed that the person had been weighed monthly and there was a gradual increase seen and they were stable at a weight of 66kg.

The chef was aware of people's likes, dislikes and any allergies and a list of these were maintained in the kitchen. The chef told us that they regularly held meetings with people to discuss the food provided to them. On the day of our inspection one of these meetings took place. People fed back in this meeting that they had been very happy with the meals that had been provided during the winter season and they gave the chef a round of applause. People were asked for their suggestions for the spring/summer menus. Ideas put forward by people included more salads with cos or midget gem lettuce, salmon, broccoli, cold meats, eggs benedict and bubble and squeak.

People received support to keep them healthy because staff worked effectively with other healthcare services. People and their relatives told us that the GP and other health professionals visited regularly. People told us that a doctor visited the service regularly and arrangements could be made for them to be seen if necessary. Records showed when the GP had been called to review people, the reasons why a review had been requested and the outcome of the GP visit. Records also showed when other healthcare professionals such as the tissue viability nurse, and the chiropodist saw people. One relative told us, "[Family member] had a health issue following a fall a few weeks ago and the staff reacted very quickly and called the GP out."

People lived in a service that had adaptations made to meet their individual needs. The flooring was plain coloured carpets, which reduced the risk of people with visual impairments relating to dementia from becoming disorientated. There was also signage around the home to help people living with dementia navigate around the environment. People had walking aids and wheelchairs to help them with their mobility needs. Hoists were used for those who required this and people had their own individual slings. All equipment used was serviced in line with the manufactures' guidance to ensure it remained in a good state of repair and was safe for people to use. The corridors were bright and clutter free that helped to reduce the risk of people tripping or falling.

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.

Where people lacked capacity to make certain decisions, appropriate assessments had been completed to

ensure the requirements of the Act were met. For example, one person had a selection of decision-specific mental capacity assessments. These assessed their capacity to consent to their care plans for mobility, personal care, night care, continence, medication, skin care, medical wellbeing, emotional wellbeing, nutrition, end of life and leaving the building. They had a DoLs dated June 2017.

Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

Good

Our findings

People were treated with kindness and compassion in their day-to-day care. People told us that staff were caring and kind people. One person told us, "It is a friendly place with all the staff." Another person told us, "I call the staff my angels they treat me very well." A third person told us, "On the whole I like it. The staff have to help me with everything and they are kind." Relatives told us that staff were very caring and regular staff knew their family member well. One relative told us, "[Family member] has struck up a good relationship with one particular member of staff who regularly sits and helps him." We saw this during our visit.

People were supported to express their views about the care they received. The provider told us in their PIR that people and their relatives were involved in the care planning process and we found this to be the case. The registered manager has commenced a 'Resident of the Day' whereby the RNs review individual care plans with them. People and their families were also provided with the opportunity to meet with the house keeper, activities person and a member of the catering team to discuss any issues or changes they would like to make. One relative told us that they had been included in their family member's care plans and they were always notified of any changes.

We observed some nice positive interactions between staff and people. For example, a staff member was giving a person a manicure in the lounge. Music was playing softly and we could hear them quietly discussing the colours of nail polish. The staff member then unprompted said, "You sound thirsty, would you like a drink?" and got the person a juice from the kitchen. Another person came in shortly afterwards. The person was in a wheelchair and staff spent a lot of time choosing the right spot for the person. They then came and sat next to us and staff said, "I know you love the view." And the person looked happy to be sitting next to the large window looking out over the gardens and woodland.

People received support from staff who knew them and had read their care plans. Care plans contained information about people's backgrounds and their preferences. Staff displayed a good knowledge of these when we spoke with them. One member of staff was able to explain how to support a particular person. The member of staff said that the person prefers one carer and that sometimes they were more willing to do things that than at other times. They also knew that the person liked TV and last of the summer wine was their favourite programme.

People's privacy, dignity and independence were promoted by staff. People told us that staff attended to their personal care needs in the privacy of their bedrooms and with the curtains closed. One person told us,

"Yes they [staff] are good when helping me; they always shut the door and make sure I am positioned where I can't be seen if someone was to suddenly come in. They cover me with a towel to make sure I do not get cold when I am washing. I feel very safe with the regular staff." Staff told us that they respected people's privacy and dignity through knocking on bedroom doors, undertaking personal care in bedrooms with the doors closed and ensuring that they covered exposed parts of the body. We observed this practice throughout the day. We observed one person being supported to their room for personal care. The member of staff closed the door behind them. When the person came out of the room we saw the member of staff opening curtains which had been shut to afford privacy whilst they were supporting her. One person was self-medicating one medicine. An appropriate self-medication assessment form was in place and had been signed by the person. This showed that the service promoted independence and involved people in their care.

Staff told us that they encouraged people to be as independent as they were able. We observed people freely accessing the communal areas of the service and sitting talking to each other. Staff told us that they always encouraged people to wash themselves independently and they were always available if they required any support with this. One person told us, "They [staff] do help me maintain my independence. Once a week I go out and they get me ready in time to go."

People were able to practice their religious beliefs. The service had religious leaders visiting to provide services for people who continued to practice their faith.

People's visitors were welcomed at the service. Relatives told us that they could visit the service at any time. One relative told us that they visited every afternoon and they could spend their time with their family member in their bedroom.

Good

Our findings

People were involved in their care and support planning. People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. When we asked people about their care plans all they could tell us was that they were reviewed every month. Speaking with staff they were able to explain how they attended to the needs of people and were knowledgeable about the contents of care plans and the risk assessments pertaining to individual people.

People received care that was personalised to their needs. Care plans and care was person centred and included information in regard to people's personal care, oral hygiene, skin integrity, communication, falls, medicines, social needs, sleep, end of life and dementia. Dementia care plans had been written for people and recorded their likes, preferences and communication needs. For example, it was recorded that one person who was living with dementia liked it if you sought their advice about cars. This was because they were a car lover and used to drive a BMW. It was recorded that once they were engaged talking about this they might respond positively to personal care. Their communication plan included that they required visual prompts to make choices.

Information in care plans was inconsistent. In some cases we found detailed information on people's preferences but in others this was lacking, and we have reported on these inconsistences under the Well led domain. Some care plans included a personal life history and included details of people's preferences and choices, for example, one person liked to watch channel 4 television and they communicated with a family member, who was living abroad, on a video call. The registered manager had identified this in their improvement plan and a date was set for all people to have their life histories recorded by the end of June 2018.

People had access to a range of activities, to keep them entertained and stimulate their minds. There was a variety of activities offered each month. These included 1:1 activities in people's bedrooms, classical music, reading, films, art, bingo and external entertainers visiting the service. Twice a month there was a church service for people who practiced their religion. There were also external outings arranged for people to take part in. There was a large activity room at the service that was rarely used. The registered manager told us that this would be utilised when more people moved into the service.

The provider had just introduced a coffee bar in the lounge on the day of our visit. The registered manager told us that this was an on-going activity that would help people to sit and engage with each other. We saw

people choosing the coffee and biscuits of their choosing and sitting and conversing with each other.

People's views about the activities provided were mixed. Some people told us that some of the activities on offer did not appeal to them or did not interest them. One person commented, "I don't want to sing Vera Lynn songs and be reminded of the war. I lived through it." However, we noted that people's views about the activities they would like to do had been sought through resident meetings. For example, at one meeting people were asked for their feedback about the in-house activities and outings. These were mainly positive, for example, people had stated they enjoyed the entertainers, the BBQs and trips out of the service. People fed back about how they had enjoyed a trip out to a museum and they were able to put forward other ideas for other outings. A lot of activities had been organised for the Christmas period and had included visits to Guildford Cathedral and garden centres. A local Brownie had visited to entertain people with carols. There were no negative comments about the activities provided at the service in the survey that was undertaken in March 2018.

People were provided with information about how to make a complaint. There was a complaints procedure available to people, relatives and visitors and this was displayed at the home. This was also in a pictorial format and included pictures of the registered manager and contact details for the provider and the ombudsman. We noted that nine complaints had been resolved within the timescales specified in the provider's complaints policy. People we spoke with had not made a formal complaint so told us that they did not know if things would change as a result of making a complaint. The service had also received many letters of compliments. For example, people and relatives thanking staff for their kindness and care provided to them and their family members.

People were supported at the end of their life to have a dignified and as far as possible pain free death. People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. We noted that end of life care plans documented whether people wished to be admitted to hospital or not. People's family and GPs were involved in their end of life care. The registered manager told us that staff would be supported by the local McMillan's Trust when people were receiving end of life care.

Requires Improvement

Our findings

Not all records included all full guidance to help ensure that staff were able to deliver the care people needed. For example, one person who was living with dementia spent a lot of their time in their bedroom asleep in their armchair. The risk assessment document stated that four hourly checks were required. We noted that staff would sometimes go into the person's bedroom but there was no interaction between the staff and the person. Records from healthcare professionals informed that this pattern of behaviour was appropriate for the person as they liked to 'cat nap' in their armchair. It also stated that the person should not be disturbed when they were asleep as this would cause them to become agitated. The person's relative told us that this was best for their family member and they had agreed to this. The registered manager told us that staff regularly went in to the person's bedroom to check them. However, there were no records of these checks. The registered manager has, since our visit, forwarded a template for recording these checks and the type of interaction that took place with the person at that time; this must be embedded into practice.

Accidents and incidents were recorded but the action recorded to prevent further accidents was not clear. One person had an unwitnessed fall with no injury. The recorded action was 'remind to use call bell' despite the person having a cognitive impairment. However, evidence recorded in the person's care plan informed that staff were aware that the person was not able to remember to use the call bell. It was recorded that the person had a 'mild cognitive impairment'. These documents showed that reminding this person to use the call bell was not effective to manage this risk to help avoid further falls. We asked this person about how they would call staff. They were not aware that they had a call bell. We noted that the call bell was not within reach for them to use.

The registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The registered manager had been in post since April 2017. Staff told us that the service was well led and they felt supported by the management and nursing team. One member of staff told us, "The management are

really nice. I can talk to the manager and deputy manager at any time, they are very supportive." Another staff member told us, "The management are always working on the floor." A visiting healthcare professional told us that they had seen improvements during the last twelve months. They told us, "There has been a lot of changes for the better especially with staff who are very caring. The atmosphere is friendly, relaxed and efficient." The deputy manager told us that they had a challenge to develop a team, which was fractured and demoralised when they took over and that it was a positive experience to develop the new team.

The service promoted a positive culture. There was a staffing hierarchy at the service that consisted of the registered manager, deputy, both of who are qualified nurses, nurses, team leaders and care staff. Staff knew what their individual roles were and the duties they were to perform. Regular staff meetings took place where staff were able to discuss people's needs to ensure they were provided with care in a consistent way. For example, topics had included the allocation of staff to meet people's needs, nutrition and hydration, training and safeguarding. Regular RN meetings also took place where the needs of people were discussed and updated. Staff told us they were able to discuss what it was like at the service and could make suggestions about how to make improvements. For example, one member of staff told us that they had asked for the seating arrangements in the sitting room to be re-arranged and this had been completed.

Quality assurance systems were in place to monitor the quality and running of service being delivered. The provider told us in their PIR that provider visits were carried out by the director of care and quality and detailed reports were produced. We found this to be the case. Audits included infection control, staff recruitment files, health and safety, fire, the environment and medicines. Actions had been taken when issues had been identified. For example, it was noted that staff would require training in regard to diabetes as one person had been admitted to the service with this condition. We noted from the training programme that this training had been provided.

People and those important to them had opportunities to feedback their views about the home. A survey to ascertain the views of people, relatives, staff and other stakeholders had just been completed in March 2018. The provider had sent analyses of the responses to the registered manager and an action plan was to be produced about how to address any issues identified. There were many positive responses in the analyses. For example, people were satisfied with how staff treated them, the help they received from staff, being involved in the planning of their care, satisfaction with activities and how to make a complaint. Comments in the surveys from people included 'I am free to come and go as I please.' 'Excellent food.' Plenty of activities.' 'Staff are kind.' 'Staff work hard and have created an efficient but relaxed atmosphere and are never too busy to give help.'

The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home evidenced that staff work closely with the local safeguarding team, adult social care teams and all healthcare professionals. For example, GPs, physiotherapists and dieticians.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission and other outside agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.