London Residential Healthcare Limited

Belmont Castle Care Home

Inspection report

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Date of inspection visit:
15 April 2019

Date of publication:
30 May 2019

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: Belmont Castle is a residential care home that is registered to provide accommodation and personal care for up to 40 people. At the time of the inspection 32 people were living at the home. People living at the home had a range of care needs, including people living with dementia.

People's experience of using this service:
Risks to people and the environment were not always effectively managed though robust assessments to ensure people were appropriately protected.

Medicines were not always safety managed in line with best practice guidance. Medicines administration timings were not always recorded accurately.

We received mixed feedback from people and their relatives about being involved in the planning and reviewing of their care.

People's rights and freedoms were not always protected. Where people were considered to lack capacity, systems and processes did not always reflect compliance with the principles of The Mental Capacity Act 2005.

Care records and daily recordings were not always consistently completed to reflect that people's needs were always met.

There were clear systems and processes in place to protect people from the risk of abuse, and the home promoted an open and transparent culture.

People and relatives told us they were happy with the care and support provided. People told us staff were caring and they felt comfortable in the home.

We received positive feedback from people that they enjoyed the quality and choice of meals provided.

The environment was suitable to meet people's needs and the design and layout was supportive of people living with dementia.

The home ethos promoted people to be treated with dignity and respect and people were supported to maintain their privacy.

People were encouraged to make their own choices and decisions as appropriate, and staff supported people to have control over their day to day routines.

People had access to an extensive range of activities to meet their interests, which were flexible to meet their individual needs.

There was a clear management structure in place, and the registered manager had established positive relationships with people and their relatives.

Rating at last inspection: This service was previously rated as Good at the last comprehensive inspection. That report was published on 21 February 2017.

Why we inspected: This was a planned inspection based on the previous inspection rating.

Enforcement: We found three breaches of Regulations. For actions we told provider to take, please refer to the end of this report.

Follow up: We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with our inspection timescales for Requires Improvement services.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Belmont Castle Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection was carried out by two inspectors and an expert by experience with an area of expertise in dementia care. 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: Belmont Castle 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. The care home accommodates up to 40 people, including people living with dementia in one adapted building. The home was laid out across three floors with lift access, and 17 of the 19 bedrooms offered en-suite facilities.

The service had a manager registered with the Care Quality Commission. 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. The registered manager had not changed since the last inspection.

Notice of inspection: This planned comprehensive inspection took place on 15 April 2019 and was unannounced.

What we did: Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we gathered information from:

Nine people using the service
Six relatives
The registered manager
The area manager
12 members of staff including care, house-keeping and maintenance staff.
The cook
Three health and social care professionals
Observations of residents and staff interactions including meal times
Records of accidents, incidents and complaints
Audits and quality assurance reports
Environmental risk assessments and building maintenance certificates
Medicine Administration Records (MARS)
Health and Safety Records, including fire safety practices
Three staff records including recruitment practices
A range of care records for ten people

After the inspection we gathered information from:

Resident and staff meeting minutes
Staff training records
Six weeks staffing rotas

Requires Improvement

Is the service safe?

Our findings

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

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:
• Guidance for the management of risks associated with people's safety was not always sufficiently detailed to mitigate the risk of harm. For example, where a person required varying levels of support depending on their mobility needs and presentation, records did not clearly and consistently evidence potential risks posed to the person or detail when, where and how staff should offer different levels of moving and handling support to keep them safe.
• Where people had specific health needs such as a diagnosis of diabetes, care plans were not in place to ensure staff knew how to prevent, monitor and mitigate potential associated risks to people, such as detailing signs and symptoms staff should respond to and types of support people may require to maintain their health and wellbeing. We brought this to the attention of the registered manager. They told us they would review people's care plans in partnership with the community district nursing team to ensure they fully reflected how risks would be safely managed.
• Risk assessments were not always in place for people who were prescribed anticoagulants medicines. People who are prescribed anticoagulant medicines can be at an increased risk of bleeding as these medicines are a blood thinner.
• We identified not all environmental risks had been appropriately assessed to keep people safe. Most environmental risks were assessed, monitored and reviewed regularly. Risk assessments included fire safety, COSHH, and water temperature monitoring and checks. However, consideration of the use of free-standing radiators throughout the home had not been risk assessed, including where people were identified as being at a higher risk of falls. Following the inspection, the provider told us they had removed the equipment from people's rooms and alternatives were being considered.

The failure to consistently assess and take all reasonable practicable steps to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
• Medicines were not always managed safely. We observed staff did not accurately record the time of controlled medicines administration and medicines which were prescribed to be administered several times a day. This meant people were at risk of not receiving their medicines as prescribed.
• We saw that some people were prescribed medicines that were required to be administered prior to food. We found that staff were not always administering these safely and staff said they could not be assured they were given prior to breakfast.
• Systems to monitor the safe storage of medicines were not always effective. We reviewed the home's systems and processes around the safe and effective storage of medicines in line with manufacturers guidance. We found that staff responsible for managing medicines recorded fridge temperatures where

medicines were stored to ensure they were safe to use, however maximum and minimum temperatures were not being monitored in the medicine's storage room placing these medicines at risk of being unsafe to use.
• Staff responsible for managing medicines completed and recorded regular stock counts of medicines on the premises. We found that records demonstrated staff undertook this check regularly, However, one person's medicines count was inconsistent with the amount recorded in the audit carried out by staff on the day of inspection. Staff were not able to account for the discrepancy which meant people may not have received their medicines as prescribed.
• Staff who undertook a role in supporting people to receive their medicines were appropriately trained and all except for one staff member had undergone medicines competency checks with the registered manager.
• Where people had prescribed topical creams, these were managed safety.

The failure to ensure the safe and proper management of medicines was as a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• People we spoke with consistently told us they felt safe. One person told us, "Yes [I feel safe]. It's the people [staff]. They help you with anything." and a relative we spoke with said, "I think [relative] is safe."
• There were appropriate systems in place to protect people from abuse when accidents or incidents occurred. We reviewed records completed by staff and the registered manager where concerns had been identified and saw appropriate steps were taken to keep people safe. This included contact with other organisations such as local authority safeguarding teams where this was appropriate.
• Staff we spoke with knew how to raise concerns with the registered manager and external agencies to keep people safe if this was needed.

Staffing and recruitment:
• People told us they had access to appropriate levels of staff support to meet their needs and we reviewed staffing rota's which confirmed this.
• There was a clear recruitment pathway for new employees. This included disclosure and barring service (DBS) checks for new staff before commencing employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with.

Preventing and controlling infection:
• The environment was clean and tidy and a relative commented, "We've been to many homes, to visit people and when I was looking for a home for [relative]. This one never smells, and I think that is important." A regular visiting healthcare professional tod us, "Every time I come it's always clean."
• There was clear delegation of cleaning tasks between the house-keeping staff and care staff, which was overseen by regular audits completed by the registered manager.
• Staff had access to personal protective equipment such as disposable gloves and aprons, and we observed staff used these consistently when providing care to people.
• Staff had access to training on infection control and COSHH (Control of Substances Hazardous to Health) to support them in their roles.

Learning lessons when things go wrong:
• The registered manager ensured all accident, incident and safeguarding records were monitored and reviewed monthly. The registered manager maintained oversight of any actions required and evaluated information to identify any themes or triggers and taking steps to prevent reoccurrences.
• The registered manager told us that the provider ensured information was shared between Belmont Castle and their other homes at regular planned meetings for senior management. The registered manager said

this provided a good opportunity for the group to share information on lessons learnt, outcomes of safeguarding actions, best practice and knowledge. We reviewed a sample of recent minutes of these meetings which demonstrated an open and transparent culture was promoted.

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.

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 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.

- The registered manager told us that some people living at Belmont Castle were unable to give informed consent to their care and support planning as a result of a cognitive impairment. However, this information was not always clear in people's care records.
- Where people were unable to consent to care and treatment, some care records failed to demonstrate that people's capacity had been consistently assessed in line with the Mental Capacity Act 2005. For example, where people who were unable to provide informed consent were supported to maintain their safety using sensor mats.
- We found some people's care records failed to identify where actions had been taken or considered to be in peoples 'best interest' and demonstrate why, how, or when the decision had been made, who had been involved in making the decision and what else had been considered.
- We also found where people were identified to be supported to make decisions by relatives or important people through enduring or lasting power of attorney, we could not be assured records held lawfully permitted others to make decisions on behalf of their loved one.

The failure to ensure care and treatment was provided in line with the Mental Capacity Act 2005 where people could not provide informed consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed staff regularly seek verbal consent from people before supporting people to meet their needs. For example, staff asked people if they required any assistance and where this was declined staff respected people's wishes.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- We saw most people had appropriate applications made to the local authority where they were identified

by the registered manager as being unable to consent to their living arrangements at Belmont Castle. However, one person's care file we reviewed who had an active DoLS application in April 2018 had inconsistent information in their care plan regarding their ability to make decisions. The registered manager confirmed "You have highlighted something we did not notice." Following feedback the registered manager told us this information would be reviewed and steps taken to address this.
• The registered manager kept a record of all DoLS applications, and regularly followed up pending applications with the relevant authorising body.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The registered manager and senior care staff completed assessments of people's care and support needs before they moved into the home, which included people receiving respite or short stays.
• Technology was used to support people to meet their care needs. For example, there was a call bell system in place and a person told us, "Yes and they come quite quickly when I press it."
• We also saw some people who were at risk of falling had pressure activating mats to allow them to have privacy in their rooms whilst maintaining their safety.

Staff support: induction, training, skills and experience:
• Staff told us they felt supported by the registered manager and records reflected that staff received regular supervision and appraisals from senior members off staff.
• When new staff were recruited, we saw records that confirmed they were supported through a planned induction programme. This included shadowing opportunities with more experienced staff and the provider supported unexperienced care staff to complete the care certificate, which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
• People were supported by staff who were appropriately trained for their role. The registered manager was passionate in supporting the staff team to gain confidence and skills through regular learning opportunities and training courses. A person told us, "The [staff] really care and have the training to go with it."
• The registered manager ensured people and junior staff were supported on each shift by an experienced senior staff member. Staff also told us they could use the on-call system at any time if they needed support from the home's management.

Supporting people to eat and drink enough to maintain a balanced diet:
• People and relatives' we spoke with consistently told us the food on offer was good quality and enjoyable. We received comments such as, "[Chef] goes a step beyond and gets my evening snacks, for example sausage rolls and pasties. [Chef] restocks as required with no extra cost involved" and "Lunch is always very nice, breakfast is great, and supper is sandwiches with plenty of choice."
• Relatives were encouraged to stay for meals with their loved one and staff were flexible to support this. A relative commented, "It's [food] superb. I'm staying for lunch. I don't eat with [relative] as they try to get me to eat theirs" and another relative told us, "We've always been offered tea or coffee and have been offered lunch."
• We observed meal times to be a relaxed and friendly experience for people. People were offered choice of where they would like to eat their meals and we observed staff sit and enjoy lunch with people.
• Where people required additional monitoring of their food and fluid intake we saw daily records were completed. This supported staff to identify any concerns or changes to people's intake so they could respond. A relative told us, "I think it is really lovely here, [relative] has put on weight since they have been here which is good."
• Where able people were encouraged to be independent accessing drinks and snacks between meals. Kitchen staff regularly filled snack baskets with fruit, chocolates and crisps and people could access an ice

cream freezer and cold drinks cabinet. We received feedback from a social care professional who told us, "I was impressed that around the living areas there were fridges of cold drinks and freezers of ice lollies to encourage the residents to be hydrated; they could help themselves."

Staff working with other agencies to provide consistent, effective, timely care:
• A visiting healthcare professional spoke positively of the care people received and relationships between the district nursing team, the registered manager and staff. They told us they thought people's needs were well managed and staff quickly sought external professional help when needed.
• People told us they were supported to maintain their physical wellbeing through a range of visiting professionals such as district nursing teams, GP visits and opticians. A person commented, "I get upper respiratory tract infections and know when it's starting. I said to one of the team leaders and they phoned the surgery. The nurse practitioner visited, and I got my antibiotics" and a relative said, "The district nurse visits every morning to give them their insulin."
• People's care records detailed contact with health and social care professionals and contained information shared at visits to ensure staff were up to date with people's care and treatment needs.

Adapting service, design, decoration to meet people's needs:
• Bedrooms were personalised with people's furniture and photographs displayed. A relative contacted us and said, "My mum's bedroom is lovely, [there is] a great view from her window and [it's] always warm. The main areas are decorated in a way to stimulate memories and encourage conversation".
• The provider regularly invested in the home's aesthetic design and decoration. The registered manager was passionate in developing a dementia friendly environment and tailored the homes decoration to promote stimulation and reminiscence. Communal areas were themed with bright visual pictures and objects to encourage people to interact and engage with their surroundings.
• The building decoration incorporated dementia friendly signage to promote people's independence, for example hand rails and bathroom doors were bright visual colours. A visiting healthcare professional commented, "The home decoration always changing."
• People at the home had access to a lift and stair lift to support them to move between floors where appropriate.
• People had access to the home's grounds which was also designed to provide a sensory experience for people living at Belmont Castle.
• There was a dedicated maintenance man who was responsible for the general day to day upkeep of the property.

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.

People were supported and treated with dignity and respect; and involved as partners in their care

Ensuring people are well treated and supported:
• We observed people were treated with kindness and consideration by staff. People seemed comfortable in their interactions with staff and each other. One person told us, "I came in on a Friday, on the Sunday I cried because I was overwhelmed by the kindness shown to me." Another person said, "Some ones [staff] are cheeky, but I like that. Better be cheeky than miserable."
People told us they felt staff went the 'extra mile' and a person commented, "On Mother's Day (I have no family), some of the staff said, 'we are going to adopt you'. I had a present, a lovely nightie and a bunch of tulips. I cried it was so lovely."
• A relative told us, "I was worried that a larger home may not be so personal, but this home goes the extra mile to ensure each resident is acknowledged and we'll cared for."
• Staff were committed to providing person centred care to people and demonstrated a good understanding of people's preferences, interests and dislikes.

Supporting people to express their views and be involved in making decisions about their care:
• We received mixed feedback from people and their relatives about their involvement in care planning and reviews. For example, one relative felt they were "Definitely" involved in care planning, however another relative told us, "I wasn't involved. I know they have a care plan, but I'm not involved."
• We observed staff regularly interacted with people to seek their views and wishes.
• We reviewed records of residents' meetings which were held regularly. The registered manager told us these meetings provided an opportunity for people to be involved in planning future events, be consulted on any changes happening and discuss any concerns people may have.
• The registered manager had a good understanding of equality, diversity and people's rights. The registered manager discussed how they supported people to continue to embrace their religious and cultural beliefs and things that were important to people.

Respecting and promoting people's privacy, dignity and independence:
• Staff understood their responsibilities when respecting people's privacy and people could choose to spend time alone in their rooms.
• Staff spoke with people in a dignified and respectful manner. A person told us, "[Staff are] always polite."
• Care records reflected people's choice over their daily routines. For example, one person's care record prompted staff to offer choices of clothing, so the person could choose what they would like to wear.
• People's care records also reflected people's likes and dislikes, including favourite toiletries and preference of staff gender for support.
• Where people required additional measures to support them to make choices, staff supported this through ensuring accessible information was available. For example, people could be supported to use picture cards

for menu choices where this was needed to promote their independence.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• We reviewed three people's personal care records and found that two of the three people's daily notes failed to reflect if and what support had been provided to meet their personal care needs. We could not be assured all people were receiving consistent care to meet their needs.
• The information recorded in some people's daily notes contradicted guidance in their care plans about the support they required around their personal care. For example, one person was identified as requiring staff support to meet their personal care needs. Their daily records indicated the person had completed these tasks independently.
• The registered manager acknowledged the need for improvement in staffs recording of support offered and received to provide assurances that people's needs were sufficiently met.
• Where people were prescribed medicines on an 'as required' (PRN) basis such as pain relief, we found PRN protocols lacked person-centred planning to ensure staff knew what, when and why these should be administered.
• Where a person was prescribed PRN medicine to manage and support periods of anxiety and/or distress, we found care records were not in place to ensure staff knew how to identify, monitor, support and respond or when the use of medicine should be considered.
• People did not always have an end of life plan in place. Some people's care records we reviewed included end of life care plans which detailed their future wishes and arrangements for support when this was needed, however we found plans were not consistently in place for all people.

The failure to ensure accurate and contemporaneous were kept was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Where people had identified additional needs, we saw care records reflected professional guidance and detailed plans. For example, where people were prescribed a modified diet by the speech and language therapist, plans detailed people's needs, choices and preferences to meet this.
• People were supported by staff to maintain their interests and had access to technology to support them to make choices. This included smart televisions in communal area's which connected to the internet and an electronic tablet with pictorial software.
• There was a dedicated activities staff member in who supported people five days per week. People spoke highly of the activities provided and we saw people were given an abundance of opportunities to engage in a range of events, planned trips and hobbies within the home.
• A healthcare professional told us, "It's one of the best home's we go to activity wise" and a relative commented, "On a Thursday they have 'toddler tea'. Its lovely, people bring their little ones, have a bit of tea and one of the residents reads the children a story. It's lovely."
• Where people had an interest in computing and use of the internet this was catered for and residents had

access to the home's wi-fi internet connection.
• People were invited to participate in regular meetings to share their views on the care provided and activities they would like arranged. The registered manager also chaired regular relatives' meetings to support the homes ethos of inclusivity and a relative commented, "I've been to one [relatives meeting]. [Relative] had only been here two weeks but I found it really useful for finding out information and getting to meet other relatives."
• Traditional holidays were celebrated such as Christmas and Easter and people and their families were invited to join in with parties. Where people valued different religious or cultural beliefs, this was catered for and staff told us they supported people to watch weekly ceremonies on live stream from St John's Cathedral.

Improving care quality in response to complaints or concerns:
• There was a complaints procedure in place and people told us they felt comfortable in raising concerns. Comments from people included, "The manager gets a complaint, looks at it and investigates. Then talks to the complainer and sorts things out." and "I've never had any concerns but if I did I would speak to the senior on duty."
• People and relatives were encouraged to provide feedback and raise and queries at residents and relative meetings. The registered manager told us they took people's feedback seriously and aimed to resolve issue's quickly. Information about concerns raised was also shared where appropriate with staff during handover times and the registered manager told us they adopt a "whole team approach" to making improvements.

End of life care and support:
• The registered manager told us they had attended the gold standard framework training to enhance their knowledge. The Gold Standard Framework is a nationally recognised approach to providing effective end of life care. Staff were supported to gain skills through bereavement training. We review training records which confirmed staff were provided with training opportunities to support people end of life care.
• We saw communication from the provider commending and valuing the staff team's contribution at Belmont Castle in April 2019 following a celebration of life event held in memory of people who had passed away. Comments about staff's approaches included, "The detail that [staff member] makes goes the extra mile, it even included a request from a [person] to have whisky as a mouth swab" and "Families comment that [staff member] empathy and support which is a great comfort at difficult times. Her passion is treating a resident who is at end of life with exceptional standards of dignity and respect."
• The registered manager told us that they worked closely with external healthcare professionals to respect people's wishes and provide them with the care they required to be pain free and cared for at the end of their life.
• A visiting healthcare professional confirmed they felt staff supported people's end of life needs well.

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.

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:
• The provider had quality assurance processes in place to monitor and review the overall delivery of people's care and the service provided, however they were not always effective in ensuring safe management of risks to people or the environment.
• Audits of people's care files were not robust in identifying or driving improvements in line with our findings, processes failed to ensure all care records were an accurate and a consistent reflection of people's needs.
• We reviewed medicines audits completed in April 2019 which had identified areas for improvement, for example ensuring people's MARS records were consistently signed by staff. However, the audit was not effective in identifying the concerns we found at this inspection or ensuring medicines were managed in line with best practice guidance.
• The provider had recently established a quality and compliance team for the group to support registered managers to evaluate the overall operation of the service and care provided, however they had not visited the service before the inspection. Therefore, the service had not benefited from input from this team. The area manager told us the provider recognised quality assurance processes required improvement and steps were already in place to make systems and processes more robust.
• There was a clear management structure in place which included the registered manager, senior and junior staff members. Staff were aware of people's differing roles and delegation of tasks, for example additional responsibilities of shift leaders to complete medicine administration.
• Management and staff communicated effectively and there was an open and transparent culture to service delivery. This included regular daily meetings with representatives from care, housekeeping and maintenance staff to share information about residents' daily presentation, concerns and actions required.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• We saw the registered manager and people had built positive relationships and there was a high level of regular, comfortable interactions.
• The registered manager had a good understanding of their duty of candour requirements. The duty of candour sets out actions that the registered manager should follow when things go wrong, including making an apology and being open and transparent.
• Staff consistently told us they felt supported by the registered manager and were encouraged to develop their knowledge, skills and interests.
• A visiting healthcare professional told us, "The [registered] manager is really good, clearly in it for the care".

Continuous learning and improving care:
• The registered manager was personally and professionally committed to promoting people's quality of life. They were open and transparent to feedback from our findings during the inspection and told us, "Sometimes you need fresh eye's, I am committed to making this service outstanding no matter how long it takes."
• The provider and registered manager used an electronic action plan to record and monitor improvements they identified with clear timescales for actions to be completed.
• The registered manager encouraged feedback from people, relatives and professionals through annual surveys.

Working in partnership with others:
• The registered manager encouraged partnership working and community networking. For example, they had established networks with a local school who visited the home regularly and provided work experience for people with a learning disability to promote inclusivity.
• The registered manger told us they had positive working relationships with external professionals and sought advice and guidance where required to meet people's needs.
• Working collaboratively with people and their relatives was highly valued by the registered manager. For example, the registered manager extended offers of training to relatives to support people's knowledge and understanding of dementia and appropriate moving and handling with their loved ones to promote positive relationships.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Appropriate consent was not always sought. Where people were identified as lacking capacity, decision specific assessments were not always in place to demonstrate where actions were taken in people's 'Best interest'.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Medicines were not always effectively managed to assure people's safety. People's risks were not always assessed. Support plans were not always sufficient to ensure staff provided safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The failure to maintain securely an accurate,

complete and contemporaneous records for each person or to operate effective processes to ensure compliance with Regulations.