Care UK Community Partnerships Ltd

Beech Hurst

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

We inspected Beech Hurst on 25 and 27 September 2018 in light of information of concern that we had received in respect to specific incidents in people's care. Beech Hurst 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. Beech Hurst is registered to provide care for up to 60 people, with a range of health conditions, including those who were living with dementia and some with a mental health condition. On the day of our inspection there were 41 people living at the service, who required varying levels of support. We previously inspected Beech Hurst on 20 March 2018 and found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make improvements and these actions have been completed. However, at this inspection, we found further areas of practice that needed improvement.

A registered manager was 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.

Healthcare was accessible for people and appointments were made for regular check-ups as needed. However, we identified issues in relation to the systems of recording and communication between staff and other services. We saw two examples of how people's changing healthcare needs were not due to poor communication and recording between staff and other services.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

Risks associated with people's care, the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were cared for in a clean and hygienic environment and appropriate procedures for infection control were in place.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included, arts and crafts and visits from external entertainers. There were visits from local churches, so that

people could observe their faith. People were also encouraged to stay in touch with their families and receive visitors. The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff had received essential training and there were opportunities for additional training specific to the needs of the service, such as the care of people living with dementia.

Staff were knowledgeable and trained in safeguarding adults and knew what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. People's care was enhanced by adaptations made to the service.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. Staff had received supervision meetings with their manager, and formal personal development plans, such as annual appraisals.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank.

People were encouraged to express their views. People said they felt listened to and any concerns or issues they raised were addressed. Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where the registered manager was always available to discuss suggestions and address problems or concerns.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were managed and administered safely.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's changing healthcare needs were not always monitored and acted upon effectively.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

The service had arrangements in place to meet people's social and recreational needs. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People's end of life care was discussed and planned and their wishes had been respected.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We identified issues in relation to systems of recording and communicating information around people's care between staff and other services.

People, relatives and staff spoke highly of the service. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Staff had a good understanding of equality, diversity and human rights.

Beech Hurst

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.

This inspection took place on 25 and 27 September 2018 and was unannounced. We carried out this inspection in light of information of concern that we had received in respect to specific incidents in people's care. The inspection team consisted of two inspectors.

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we observed the support that people received in the communal lounges and dining areas of the service. Some people could not communicate with us because of their condition and others did not wish to talk with us. However, we spoke with four people, one visiting relative, a visiting healthcare professional, three care staff, the registered manager, a regional manager and a regional director.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including eight people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection on 20 March 2018, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks identified by the provider in relation to fire safety had not been rectified in a timely manner, systems of managing stocks of medicines and medicine recording were not robust and concerns were identified in relation to infection control. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At the last inspection, we saw that risks in relation fire safety had not been met. For example, 95% of fire doors were found at fault and not likely to cover 30 minutes of fire. The risks regarding fire doors had not been addressed and there were several other areas of concern which had not been rectified by the provider. We saw at this inspection that improvements had been made. The remedial work had been completed and our own observation and documentation we were shown supported this.

At the last inspection, we saw that some information in relation to people's medicines was not documented, for example, start dates of courses of medicines and details of specific procedures to follow when administering certain medicines. At this inspection, the registered manager showed us documentation and correspondence with the pharmacy supplier that showed improvements had been made in respect medicines being delivered. Furthermore, we saw that specific training had been given to staff in relation to administering and recording medicines. We observed a registered nurse carrying out the lunchtime medicines round safely. They followed methodical processes for preparing, administering and recording people's medicines. The registered nurse understood people's needs and supported them to take their medicines in a caring manner. They also followed guidance about when people would need medicines that were prescribed on a 'when required' basis, for example pain relief. Staff offered these medicines regularly and asked if people were in pain. We looked at medicines administration records (MARs) and saw these were accurate. People expressed no concerns around their medicines. One person said, "I've got no concerns about my tablets". A relative added, "They seem to always give out the medicines on time".

At the last inspection, we saw that not all procedures in relation to infection control were robust. At this inspection we saw that improvements had been made. The registered manager told us, "We have held meetings with the domestic team, revised their rotas and update training". We viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. There was an infection control policy and other related policies in place. We observed that staff used personal protective equipment (PPE) appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "They treat me well enough". Another person said, "I do feel safe, the staff are here". A relative added, "They take care of [my relative] she's safe".

Staff had a good understanding of people's needs and supported people to safely use equipment to assist with their mobility and maintain their independence. Staff were aware of the importance of enabling people to continue to take risks. Risk assessments were reviewed by staff to ensure they provided current guidance for staff. Accidents that had occurred had been recorded and monitored to identify patterns and trends and relevant action had been taken to reduce the risk of the accident occurring again. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency. Equipment was also regularly checked and maintained to ensure that people were supported to use equipment that was safe.

Staff had a good awareness of safeguarding. They had undertaken relevant training, could identify different types of abuse and knew what to do if they had any concerns about people's safety. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people. We saw examples of when the registered manager had liaised appropriately with the local authority in respect to safeguarding.

There were sufficient staff to ensure both the physical and social needs of people were met. When people required assistance, staff responded promptly. Consideration was made to the skills and experience of staff. Rotas showed that staff with varied skills mixes worked on each shift and work was allocated in accordance with people's needs and staff's abilities. When people required assistance from staff they had access to electronic call bells. People told us and our observations confirmed that when people used these staff responded promptly. One person told us, "When I push my bell they come to me". Staffing was flexible and enabled people to be supported appropriately should their needs change.

People were cared for by staff that the provider considered safe to work with them. Prior to staff starting work their identity was confirmed and their previous employment history gained. Security checks ensured that staff were suitable to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

People told us that staff were well trained and the care they received was effective and met their needs. One person told us, "The staff seem like they've had training, I think they are good". A relative said, "The staff are excellent and well trained, they really understand dementia. They see the person and what they need, not just the condition". However, despite the positive feedback, we identified areas of practice that need improvement.

People's told us that their healthcare needs were met and they were supported to make and attend routine health care appointments to maintain their health. We were told that staff monitored people's health and well-being and supported them to access or request referrals to external healthcare services. One person told us, "They call the doctor for me if I need it". A relative said, "They take care of [my relative's] skin and make her high calories milkshakes to keep her weight up". A visiting professional added, "I have no concerns in the way that staff report and refer within acceptable timeframes. The staff have a good awareness of how to treat pressure damage". One member of staff told us, "I always grab the nurse if I have any concerns around people's health". However, as part of this inspection we looked at two specific incidents relating to people who lived at the service.

One incident saw a three delay in a person receiving prescribed antibiotics due to a failure by staff to effectively communicate at handover that the person had a urinary tract infection (UTI) and a further communication failure to chase up the prescription for antibiotics. The other saw a person admitted to hospital with pressure damage. Staff had recognised that the person needed further treatment, however, again this information had not been recorded or communicated effectively between staff. Subsequently, this person's condition deteriorated requiring that they were admitted to hospital for specialist treatment. Whilst we have established that these incidents were isolated, both incidents occurred due to poor communication and recording between staff and other services in respect to people's changing healthcare needs.

We raised both these incidents with the management of the service, who told us that they were working with the relevant investigating bodies, such as the local authority safeguarding team in relation to these incidents. We were also told that an action plan had been developed and additional training around the importance of accurate recording and timely information sharing had been implemented for staff. We saw this was the case. However, good communication between staff and external healthcare services is important to ensure that there is a joint approach to people's healthcare. In relation to these two incidents, this was not the case and people's changing healthcare needs were not met. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that requires improvement.

People's needs were assessed when they first moved into the home and they were involved in the planning of their care. Regular reviews ensured that the guidance provided to staff was current and met people's assessed needs and preferences.

People told us that they enjoyed the food and that they were provided with choice. There were pleasant dining environments. Menus were displayed informing people of the options available. People were supported to have a well-balanced diet and could choose different sized portions dependent on their appetite and preferences. People's right to change their mind was respected and they were provided with alternative options. One person told us, "If I don't fancy what's on the menu, I ask for my favourite, which is baked beans and they always make it for me". Records provided guidance to staff if people required additional assistance to eat and drink and they were supported in accordance with these. Staff sat at tables and enjoyed conversations with people. It was apparent that meal times provided a sociable experience for people. Drinks and snacks were available outside of meal times and staff were mindful of encouraging people to have access to regular drinks to maintain their hydration.

Staff received effective training and support to look after people. New staff were supported to undertake a thorough induction. They shadowed existing staff, familiarised themselves with the provider's policies and procedures and were made aware of the expectations of their role. One member of staff told us, "I had a very good induction. There was compulsory training and I shadowed other staff for two weeks, which was very helpful". Staff had access to on-going learning and development to equip them with the necessary skills to support people effectively. There were links with external organisations to provide additional learning and development for staff, such as the local authority and local hospices. Registered nurses were provided with appropriate courses to maintain their competence and took part in clinical supervisions. Staff were suitably supported and had access to regular one-to-one meetings with their supervisors. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs.

Staff had a good understanding of equality and diversity, which was reinforced through training. The Equality Act 2010 covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. A member of staff told us, "Equality and diversity is important. There is no discrimination here, I've never seen anything like that".

The adaptation of the premises assisted people to receive effective care. Signage was used to orientate people around the service and lift provided access to other areas. There were adapted bathrooms and toilets with hand rails to support people. One person told us, "The orange doors show you that it's a toilet, that's important to me".

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. 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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood

when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow.

Good

Is the service caring?

Our findings

At the last inspection on 20 March 2018, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's independence was not being routinely promoted and their dignity was not always respected. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At the previous inspection we saw examples of people being cared for in an undignified manner, for example being left unattended for significant periods of time, which had caused some distress. At this inspection we saw that people were attended to in a timely manner and were supported with kindness and compassion. We saw good interaction between people and staff. The registered manager told us, "There has been increased monitoring by the management team in relation to staff conduct. Staff now have specific roles allocated to them and there is planning of breaks throughout the day". We saw this was the case. People were not left unattended in communal areas and staff demonstrated a strong commitment to providing compassionate care. Throughout the day, staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed positive interactions, appropriate communication and staff appeared to enjoy delivering care to people.

Additionally, at the last inspection, we saw that people's independence was not routinely being promoted. At this inspection staff supported people and encouraged them, where they were able, to be as independent as possible. The registered manager told us, "We are encouraging people to get out of bed and join in around the home", and we saw this happening in practice. We saw examples of people being encouraged to be independent. One person told us, "They help me out, but I still do what I can myself". A relative added, "They encourage [my relative] to get up and out of her room. They also know that she likes her own space and they respect that too". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "I encourage people to dress themselves and do their own teeth and hair". Another member of staff said, "When people can do things for themselves we keep pushing it. We want them to maintain their capabilities".

Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "I like it here. The staff are lovely". Another person said, "They are very kind to me. They reassure me, because I worry". A relative added, "They treat [my relative] so well".

People's privacy and dignity was protected and we saw staff knocking on doors before entering and talking with people in a respectful manner. One person told us, "They always knock before the come into my room". A member of staff added, "Knocking before entering, covering people when they are having personal care and closing curtains are standard practice".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they

that they were free to do what they wanted throughout the day. They said they could choose what time they got up and went to bed and how and where they spent their day. One person told us, "I can do what I like. I tell them what to do". A relative added, "[My relative] has dementia, but they still offer her a choice". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We use specific speech cards for one resident and another lets us know what they want by their facial expressions. It's about understanding the choices they make". Another added, "Some people want to go to bed late and some want to get up early. It's their choice, as it's their home".

People were encouraged to maintain relationships with their friends and families and to make new friends with people living in the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Peoples' equality and diversity was respected and staff adapted their approach to meet peoples' individualised needs and preferences. Detailed individual person-centred care plans had been developed, enabling staff to support people in a personalised way that was specific to their needs and preferences, including any individual beliefs.

Good

Is the service responsive?

Our findings

At the last inspection on 20 March 2018, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provision of meaningful activities was not person centred and did not meet people's social and recreational needs. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At this inspection, we saw a varied range of activities on offer which included, music, arts and crafts, ball games, exercise and visits from external entertainers. Representatives of churches also visited, so that people could observe their faith. The registered manager told us, "We have rummage rooms and a dress up room. We get information from people on a one to one basis about what interests they have". We saw that this was the case and people enjoyed the activities on offer. One person told us, "I don't really join in the activities, but they always ask me to". Another person said, "I can't join in the activities at the moment, because of my health, but some staff come and sit with me and the manager has just given me this lovely colouring book". A relative added, "The activities never used to be very good, but now they have great new staff. [My relative] doesn't really like to join in, but they encourage her to and I think she has a few times". It was clear that a formal activities programme had been developed and implemented, and we saw evidence to support this.

We saw that people's needs were assessed and care plans were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together, where possible by the person, their family and staff. A relative told us, "I'm involved in care plan reviews and I go to the relative's meetings". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. Care plans contained detailed information on the person's likes, dislikes and daily routine, with clear guidance for staff on how best to support that individual. We saw that people were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plans.

The provider was meeting the requirements of the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had preferred not to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I'd make a

complaint, they know me". A relative added, "If I raise any issues, they listen to me and sort them out". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

People had access to technology to ensure they received timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time. Furthermore, the service used an electronic care planning system that was accessible for staff.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 20 March 2018, the provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people the provider's systems of quality monitoring and improvement were not robust and had not fully identified or prevented the concerns that we saw. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements. However, we identified further areas of practice that needed improvement.

At the last inspection we identified issues in relation to the assessment of risk, the management of medicines, infection control, people's independence being promoted and their dignity being respected and the provision of meaningful activities. The providers systems of quality monitoring had not routinely identified and rectified these issues. Improvement had been made and the provider undertook quality assurance audits to ensure a good level of quality and safety was maintained. The registered manager told us that regular audits of quality took place. Documentation we saw supported this, and the results of these audits were analysed to determine trends and introduce preventative measures. However, despite these improvements, we identified issues in relation to the systems of recording and communication between staff and other services. As referenced in this report, due to poor recording and communication, two people were not cared for appropriately, resulting in their changing health needs not being met. The management of the service had identified these issues and were taking steps to rectify them. However, this breakdown in recording and communication between staff and other services placed people at risk and is an area of practice that needs improvement.

People and staff spoke highly of the service and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "I've met the manager, she is very nice". A relative said, "[Registered manager] is a good manager, she has very high standards. If there are any issues, they are on the phone straight away. We speak all the time, they let me know everything". A member of staff added, "[Registered manager] is not just the manager, she is a leader".

We discussed the culture and ethos of the service with people, the registered manager and staff. A relative said, "Oh my goodness, [my relative] gets great care here. We're really impressed". The registered manager added, "We are improving all the time in the care that we give". Staff supported this and a member of staff said, "I think people get very good care here". A further member of staff added, "This may be a care home, but it's the residents home and we respect that". In relation to staff, one person said, "The staff are very good, I have my favourites, but they all care". There was also a clear written set of values displayed in the service, so that staff and people would know what to expect from the care delivered.

Staff said they felt well supported within their roles and described an 'open door' management approach. They commented that they worked well together as a team. One member of staff told us, "I'm supported, I can approach [registered manager] at any time. Any issues we have, we raise at our daily meetings and we feedback any problems". Another member of staff said, "The management are very involved with the care,

they are very helpful". A further member of staff added, "We communicate all the time. I love working here, it's like a big family". This was echoed by registered manager who told us, "We have instructed staff to take better ownership of what they do and their responsibilities. We want to empower them".

Up to date sector specific information was also made available for staff including details of managing specific infectious conditions. We saw that the service also liaised regularly with organisation within the local community. For example, the Local Authority, Clinical Commissioning Group (CCG) and a local hospice, to share information and learning around local issues and best practice in care delivery. Staff had a good understanding of equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice, for both people and staff, living and working at the service.

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. Meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. A relative told us, "I attend the relative's meetings".

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistle-blowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b)(I) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to effectively monitor and act on people's changing healthcare needs.