Aura Care Living LTD

Stratton Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stratton Court is a residential care home providing personal and nursing care to people aged 65 and over. At the time of the inspection 30 people, some who lived with dementia, were receiving support. The service can support up to 60 people.

The care home accommodates people in one adapted building and at the time of the inspection people lived on two of the three care floors. People's accommodation comprised of single bedrooms with ensuite toilet and washing facilities. Each care floor provided a lounge, dining room and communal toilets. A courtyard garden provided safe outside space for people to use.

People's experience of using this service and what we found
Improvements to the provider's overall quality monitoring system had led to improved standards of care since the last inspection. However, further improvement was needed to ensure the provider's quality monitoring system was effective in identifying shortfalls, in practice and process, so that people were fully protected, and ongoing improvements could be made.

We identified that arrangements were not fully in place to safely support people who could become anxious and exhibit behaviour of concern, originating from their dementia or mental health condition. A recognised pathway, underpinned by evidence based best practice, had been adopted by the service, but was not always followed. Action had not been taken to ensure staff had access to robust behaviour support plans which provided them with the guidance they needed to effectively and safely support people when incidents between them occurred. We made a recommendation to support the development of good practice in this area.

We identified that risk assessments needed to be developed for people who were prescribed anticoagulants and who would not be able to self-isolate successfully in a COVID-19 outbreak or if they tested COVID-19 positive. The service's monitoring systems had not fully identified that prompt action had not been taken in relation to a medicine error and had not identified that national guidance related to COVID-19 staff testing had altered so had not taken action to address this. Managers took immediate action to address these shortfalls once we made them aware of them.

People had benefited from improved processes for monitoring their health needs. A new care records system had also supported improvement in care record content and how staff accessed information about people's needs to guide them in how to meet these needs. This was except for people's behaviour needs. People's care records had improved overall, and improvements had also been made to how staff received information and guidance about people's needs. This had included improvements in the recording of consent for care and treatment. These improvements had led to improved standards of care and outcomes for people. A new care records and care monitoring system had been introduced, enabling staff to access electronic guidance about people's care quickly. People had already benefited from this as staff recorded

the care they delivered, in real-time, which was then monitored by senior care staff. Work was in progress to transfer people's more detailed care plans from paper format to the new system.

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

Access to health reviews by healthcare professionals, had been maintained during the COVID-19 pandemic and the service was part of a pilot, which would see further improvement to people's access to virtual health consultations.

Stratton Court had successfully worked with commissioners, healthcare professionals and other agencies to provide access to care and support for people who required this during the pandemic.

Leadership for staff had improved. Senior staff were empowered to support and lead their staff teams. A whole home approach was in place in relation to quality improvement and risk management.

A person-centred approach to care had been maintained. Relatives and representatives had been kept well informed and involved in decisions made about people's care, at a time when there had been limited opportunities for visiting.
People had been safely supported to remain socially and cognitively active and engaged with their relatives during the pandemic to support their wellbeing.

Arrangements were in place to ensure safe staffing numbers. Recruitment and retention of staff had remained a challenge during the pandemic, although more recently, a more stable staff team had been established. Staff received induction training when they first started work. The improved stability in the staff team was enabling managers to plan further staff development and training.

Arrangements were in place to seek and receive feedback from people, relatives and other visitors. This was used to make improvement to people's care and the service generally. Complaints were managed according to the provider's policy and procedures.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (report published 14 January 2020). The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last three rated inspections.

Following our last inspection on 3 August 2020, we served a Warning Notice on the provider. We required them to be compliant with Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 March 2021. During this inspection we found the provider had met this Warning Notice.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations. Further improvement was needed to move the rating to Good. Please see the Safe and Well-led sections of this full report

Why we inspected

This was a planned inspection based on the previous rating.

We carried out this focused inspection to check the provider had met the Warning Notice and to follow up on a previous breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-led which contain those requirements and areas of Requires Improvement.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains Requires Improvement based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stratton Court on our website at www.cqc.org.uk.

Follow up
We will request an improvement plan from the provider to understand what changes they will make to achieve the necessary improvement. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service responsive?

Good

The service was 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.

Stratton Court

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person who is a relative of older people who live in a nursing home. The Expert by Experience gathered the views of relatives over the telephone.

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

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.

Notice of inspection
This inspection was announced when inspectors arrived in the car park.

Inspection activity started with a site visit on 18 and 19 February 2021. The inspection continued virtually until 26 February 2021.

What we did before the inspection

We reviewed information we had received about the service since the last rated inspection. We sought and received feedback from the local authority and professionals who worked with the service. We used all this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and 12 relatives; 10 by telephone and two during the site visit. We spoke with four care staff, a nurse, chef, housekeeper, the registered manager and nominated individual. We reviewed seven people's care records; care plans, risk assessments and behaviour support records. We reviewed a selection of medicine management records, including medicine administration records. We reviewed three staff recruitment files and related staff supervision and training records.

We reviewed a selection of records and documents related to the management of the service. This included quality monitoring records and the quality improvement plan. We reviewed maintenance and safety records and records related to infection, control and prevention. A selection of policies and procedures were also reviewed.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek further information and clarification, from the provider, to validate evidence found. We looked further at policies and procedures, lessons learnt, staff training arrangements, COVID-19 testing and actions relating to risk assessments.

We received feedback from professionals working with the service and commissioners of health and adult social care.

Requires Improvement

Is the service safe?

Our findings

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

At the last rated inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was potential for people to be harmed.

Assessing risk, safety monitoring and management
At our last inspection on 3 August 2020 this key question was inspected but not rated as we only looked at parts of the key question which had been of concern. We found enough improvement had been made in how people's risks were assessed, and people had received safe care and treatment. Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

At this inspection we saw that previously made improvements, to how people's health risks were assessed and managed, had been maintained. However, improvement was needed to how risks arising from people's anxiety and subsequent behaviour of concern were managed, so that they and others were kept safe.

- People were not always protected from risks arising from behaviours of concern, which originated from their own or other people's mental health needs or dementia. Incidents between people had occurred and some impact from these incidents had been experienced by people and staff.
- The service had introduced a recognised care approach which supports personalised care planning for behaviour which challenges in dementia. However, not all the steps in this approach had been consistently completed.
- Records which needed to be kept, to record people's behaviour of concern along with the possible triggers for this, had not been consistently maintained. This meant the information needed to help staff formulate or adjust people's behaviour support plans had not always been available.
- Although some people's related care records gave staff guidance on how people may present when in a state of wellbeing, when distressed and then what would cause further distress, they did not provide staff with the guidance they needed to support people once their distress had escalated and it was putting them or others at risk of harm.
- Staff used the training they had been provided with, along with additional guidance, given by a manager who had experience with supporting mental health needs, to support people. Staff also took action which they thought to be the most appropriate at the time to protect people.
- This included actions which were not included in people's support plans, such as separating people and supporting people to move away from communal rooms and back to their bedrooms. This potentially put people at risk of unsafe care and support because forms of intervention were being used, which were not recorded in an individual's behaviour support plan. These may therefore not always follow best practice guidance.

We recommend the provider considers current guidance on the formulation of robust behaviour support

plans.

● Risks related to people's physical health (clinical risks) were assessed and action taken to reduce these. These included risks associated with developing pressure ulcers, loss of weight and malnutrition, choking and falls. Relevant risk assessments were completed and reviewed giving staff guidance on actions to take to reduce these risks.
● A clinical risk review meeting took place each week between senior staff and managers. During this all health risks were reviewed to ensure action had been taken to address these and to determine if the actions in place, remained effective. Records showed that adjustments to care and support were made following these meetings. Reviews from these meetings helped inform the reviews which took place with people's GPs and vice-versa, and likewise with other healthcare professionals.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and their relatives and representatives told us they felt reassured that people were safe. One relative said, "The patio doors are always locked in her room; she is safe, and I can sleep at night knowing she is safe" and another relative said, "There is a code for the lift, so I feel it's safe."
● Staff had received training on how to recognise different forms of abuse, on what constitutes abuse and how to report safeguarding concerns to senior staff.
● The provider's policies and procedures were aligned with the local authority's safeguarding procedures. This required safeguarding information and incidents to be shared with the local authority and other relevant external partners. This had not happened in one case. This had been a genuine oversight as action had been taken to safeguard people at the time and the need to report this had been discussed by managers. Managers addressed this immediately during the inspection.

Using medicines safely
● Increased risks associated with taking anticoagulants were known to staff such as bruising and prolonged bleeding. Entries in care records showed staff observed for incidents of bruising. One person prescribed an anticoagulant had fallen and bumped their head. The provider's protocol had been followed and support from paramedics had been immediately sought and the person checked in hospital for injuries and potential bleeding.
● Anticoagulants are considered high risk medicines. Information related to their risks, what to be aware of and on their safe administration, must be recorded and made available for staff in line with guidance provided by NICE (National Institute for Health and Care Excellence) for thromboembolic disease/management. Information and guidance on this was not recorded in one specific place for staff reference. This was discussed with managers during the inspection and they took immediate action to address this. We were provided with a copy of the newly implemented anticoagulant risk assessment and care plan, which staff were putting in place for each person prescribed an anticoagulant.
● People were provided with support to take their medicines as prescribed. Arrangements were also in place to support the safe administration of medicines, to people who could not consent to the administration of their medicines but who required these to maintain their health.
● Arrangements were in place for the regular review of and safe administration of, medicines used for treating diabetes, antipsychotics and benzodiazepines (medicines which have a slowing down or sedative affect). One relative said, "The doctor consulted with me to reduce some of her medication, she's much better now and feels safe."

Staffing and recruitment
● People were protected from those not suitable to care for them by safe recruitment processes being followed. Staff recruitment records however, contained some gaps. These necessitated further discussion

with the registered manager about the recruitment of staff, after which we were assured safe recruitment processes had been followed.
● This had included completed checks of nurses' registration with the UK regulator for nurses, the Nursing and Midwifery Council (NMC).
● On starting work staff had shadowed existing staff and had been monitored by managers and other senior staff. Disciplinary processes had been followed when staffs' practice or behaviour had not met required standards.
● During the inspection there were enough staff to meet people's needs. The registered manager monitored staffing numbers according to the numbers of people using the service and as admissions increased. Agency staff were used, when required, to maintain safe staffing numbers. This was organised in line with the government's guidance on restricting workforce movement between services during the pandemic. People's needs were also considered when determining numbers of staff on duty.
● The recruitment and retention of staff had been a challenge and remained so during the pandemic. More recent successful recruitment of staff into senior positions within the care team, and into supporting departments, such as housekeeping and catering, had been achieved. An activity support worker had also been recruited which provided additional support in the delivery of social and one to one activities for people.

Preventing and controlling infection
● At the beginning of the pandemic in 2020, there were concerns raised with CQC about the service's infection, prevention and control (IPC) practices. The service experienced a COVID-19 outbreak in April 2020. An IPC specialist working with the local authority provided support and an effective outbreak management plan was implemented. Lessons were learnt from this and we were IPC assured during the last inspection in August 2020. The registered manager, employed in September 2020, had continued to monitor staffs' IPC practice. During this inspection:
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We signposted the provider to resources to further develop their approach with staff testing in line with government guidance. Managers acted on this immediately, during the inspection, to prevent the spread of COVID-19 infection.

● In December 2020 the service supported the emergency admission of 26 people from another care home who had been overwhelmed by COVID-19. Staff at Stratton Court implemented a well thought out IPC plan to support them. At the same time, they successfully prevented the spread of infection to existing people living in Stratton Court.
● Steps were taken to support people to self-isolate on their arrival. Further action was taken to address risks posed by those who, lived with dementia and who could not successfully self-isolate. Managers have since implemented risk assessments in relation to people who may require additional support to remain segregated from others when infected or during an infectious outbreak.
● Where consent had been given, staff and people had been supported to receive COVID-19 vaccinations.

People had received Flu vaccinations in 2020 with consent.

Learning lessons when things go wrong

● During the inspection we identified two incidents where the provider's policy and procedures had not been fully followed. One in respect of a medicines administration error, where a stock count identifying an incorrect number of tablets was not fully investigated at the time of the count and the second in respect of a safeguarding incident which was not reported to the local authority or us.

● Learning from both these was taken during the inspection. Action was taken, during the inspection, to alter processes to prevent these omissions from happening again and to ensure the procedures in place, designed to protect people, were always followed.

● A 'lessons Learnt' tracker recorded examples of where this approach had previously been taken and had successfully led to changes in practice and process.

Good

Is the service effective?

Our findings

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

At the last rated inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
At our inspection in November 2019 we found the service could not demonstrate that people's consent or the consent of their legal representative/s had been sought in relation to people's care and treatment. Also, when consent had not been provided that the necessary requirements of the Mental Capacity Act (MCA) 2005 had been followed. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan telling us how and by when they would meet this regulation.

At this inspection we found enough improvement had been made to how consent was sought and recorded. We found the principles of the MCA were adhered to. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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's consent had been sought prior to administration of COVID-19 vaccinations and recorded. Care plans referred to care, and treatment being delivered with people's consent.
- People's care plans gave guidance on where they required support and the prompts needed to help them make decisions and choices. Care plans reviews recorded where people's abilities in decision and choice making had deteriorated along with the support now needed from staff.
- Managers and senior staff were aware of who people's legal representatives were and involved them in decisions which needed to be made about people's care and treatment; such as the administration of COVID-19 vaccinations. One relative said, "They called me and asked if mum could have the vaccine, as they have to contact us for permission as we make decisions for her now."

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- Where people could not consent to admission to Stratton Court, a decision for this had been made in their

best interest involving health and social care professionals and a DoLS application, made by the service, to the local authority. A process was in place for the ongoing submission of DoLS applications.

Staff support: induction, training, skills and experience

● Staff were provided with induction training when they first started work. This was predominantly online training, covering modules from Skills for Care – Care Certificate. One member of staff said, "I have started medicines competencies and now need to go through the form's questions. I have done 'E Learning' training, there were 20 modules" and another said, "Induction was mostly online except for moving and handling which was face-to-face." Staff were also provided with training in dementia awareness and mental awareness and challenging behaviour.

● Managers were aware that a high staff turn-over coupled with limitations resulting from the pandemic, had hampered their ability to develop the care team's knowledge and qualifications further. In response to this a staff development program had started. Discussions had been held with staff in their supervision meetings about their learning needs and development. Managers had registered some staff for vocational courses and identified other trainings, which staff would benefit from. They planned to register for these when training opportunities restarted.

● Following discussion about the further support needed for staff in supporting people with dementia and behaviours of concern, managers registered three members of staff for online dementia training during the inspection. This one-day training included 'supporting difficulties with communication and interaction'. The specific member of staff who held relevant knowledge and qualifications in mental health was also to organise further support sessions in supporting people's behaviours of concern.

● Just prior to the inspection we signposted the registered manager to information which could support the assessment of nurses' competencies when nurses employed were new to care home nursing. During the inspection the implementation of this was further discussed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law: Staff working with other agencies to provide consistent, effective, timely care

● When admissions to the home were planned, managers completed a pre-admission assessment of need, by visiting people in hospital or another care setting, when safe and possible to do so during the pandemic. When not possible, information about people's needs, preferences and choices was gathered virtually.

● People's care needs were assessed and met in line with their protected characteristics and ensuring there was no discrimination when care and support decisions were made. Feedback provided to the service from a professional, involved with one person, confirmed they were overall impressed with the progress made in terms of the person's well-being and presentation since their admission

● In the case of the people admitted during a COVID-19 crisis in December 2020, it had not been possible to complete pre-admission assessments. Instead staff worked with the information provided to them by supporting healthcare professionals, at the time, and assessed people's needs on admission. NHS mail was used by the service to ease communication with GP surgeries, Pharmacies and local authorities and to ensure the sharing of confidential information was done safely.

● People's preferences and choices had also been explored with them and with their family representatives. One commissioner commented, "Stratton Court's response was professional and an example of good multi-disciplinary working with other professional agencies. They worked around the clock to ensure that care and support plans were in place and medication was correct and up to date. They had to liaise with us, continuing health care nurses, district nurses, GPs, pharmacy, community health team, safeguarding team and our brokerage team. Stratton also completed various assessments for equipment and up-dated the community health team so that equipment could be delivered."

● Managers had also recently worked with out of county commissioners to admit people from a hospital, which within 48 hours, had to make beds available for COVID-19 positive patients. Feedback from a

healthcare professional involved in transferring these people told us pre-admission information had been forwarded to the service and, "(Name of manager) went out of his way to establish rapport immediately with service users." This involved liaising with family members to find out about people's preferences and wishes.
● Technology was used to enhance people's support, which included movement sensor equipment as part of falls risk management. The service was also taking part in a pilot for the use of digital equipment to facilitate video consultations with clinicians.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to make choices about what they ate and drank. One person who lived with dementia was supported to eat where they felt comfortable doing this to avoid them becoming distressed and not eating at all. A relative of another person said, "Mum is now eating; she was hardly eating before. The chef goes out of his way to make special foods for her to encourage her to eat and now she is gaining weight."
● Arrangements were in place to support people's specific dietary and eating requirements. People assessed as nutritionally at risk were monitored closely and appropriately referred to healthcare professionals who could provide further support; dietician, speech and language therapist and their GP.
● Arrangements were in place to support swallowing difficulties and choking risks. Textured food and thickened fluids were provided in line with the International Dysphagia Diet Standardisation Initiative (IDDIS). The catering staff prepared people's food according to IDDIS guidance and care staff followed people's individual support plans on this. One relative said, "They puree the food for the residents who cannot chew, and they put them on the plate decorated like the vegetables like carrots etc. it looks lovely and inviting."

Supporting people to live healthier lives, access healthcare services and support
● People had their health needs regularly reviewed by GPs and Advanced Nurse Practitioners attached to GP surgeries. One relative said, "The GP they have is brilliant, he keeps checking on the residents." One healthcare professional told us the support given to people with COVID-19 had been exceptional.
● When supporting the needs of people with COVID-19, or people who fell ill with other illnesses, staff liaised with, and worked alongside, GPs, paramedics and NHS Rapid Response teams to ensure people had access to emergency medical assistance.
● People's mental health needs were reviewed by mental health professionals.
● Arrangements were in place to provide activities which cognitively challenged people and which supported mental wellbeing.

Adapting service, design, decoration to meet people's needs
● People's private accommodation consisted of a single bedroom and ensuite bathroom with walk in shower for ease. Bedrooms and communal rooms were large enough to accommodate specialised equipment such as hoists.
● The care floors in use were not specifically designed with dementia care in mind, although we observed people living with dementia to be comfortable in their surroundings. The design of the care floors supported those who walked with purpose, having open and inviting communal rooms off the main corridor and features at the ends of the corridor to act as destination points and areas to rest. People had access to a spacious dining room, off each main corridor which could be sat in at any time.
● Accommodation areas could only be accessed using keypad combinations, which included the lifts. This meant members of the wider retirement community or public, who used the ground-floor restaurant, bar and library (when able to so during the pandemic) could not enter the care home without permission. The provider employed a night-porter who completed security checks on the building.
● The care home's three care floors included corridors which could be decompartmentalised. Each area

could be accessed by avoiding other areas by using various entrances including two lifts. This meant the building was ideally suited to supporting zoning and cohorting measures in an infectious outbreak.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
During our last inspection on 3 August 2020 we found not enough action had been taken to ensure care records were fully maintained and staff had access to accurate staff hand-over information to support them to meet people's needs. This was a repeated breach of Regulation 17 (Good Governance) in relation to records and the Warning Notice in respect of this remained in place.

At this inspection we found enough improvement had been made to how people's care plans, risk assessments and staff hand-over records were maintained. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- A new electronic care records and care monitoring system had been introduced. This was providing a more responsive and consistent way of recording people's care. Guidance about people's needs had been entered into the system for staff guidance. Individual risks associated with people's care had also been entered and staff could access this information through their hand-held electronic device.
- During the inspection staff were working with two systems as care plans and some risk assessments were in the process of transferring over from paper format to the new electronic system. Paper records were still in use and available for staff reference.
- Staff had received training on the system and were recording the care they delivered in real-time through their hand-held electronic device.
- Staff attended a detailed hand-over meeting at the beginning of each shift and any recent changes in needs or risks were flagged up during this meeting. A supportive and experienced senior staff team were available to support and guide staff.
- Care plans were being updated as they came up for transfer to the new system. In the meantime, entries into the care plan review section continued (on the paper format), giving staff updated information and guidance.
- Care plan reviews showed staff recording changes in people's physical abilities as well as their cognitive ability. One person's mobility had deteriorated, so guidance for staff had altered from supporting with a walking aid (as seen in the main care plan text) to using a sling and hoist in the care plan review. The person's moving and handling risk assessment had been updated for staff guidance. Another person's mental capacity had altered, so the support and guidance they needed, had altered. The care plan review told staff what areas the person needed support in to still make choices.

Meeting people's communication needs

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

● People's communication needs and how they required information to be given to them, were recorded in their communication care plans. Several people had challenges with communication and guidance was also available for staff, from more experienced staff, as well as from the care records.

● A significant impact on some people's communication abilities came from their physical disability and from living with dementia. Pictorial support and hand gestures were used to support some people. Others needed staff to know them well, which they did, to be able to read and respond to their non-verbal communication.

● The wearing of face masks had made it more difficult for some people who used a combination of listening and lip-reading to understand what was being communicated to them. We observed staff repeating themselves and speaking louder and clearer to compensate for this. No-one had become distressed by the wearing of face masks although some people needed regular reminders as to why staff needed to wear these.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had been supported exceptionally well to remain in contact with their relatives and others who mattered to them. The activities team, and other staff, had dedicated a lot of their time in ensuring people remained connected.

● Staff used technology to help people make and receive regular voice and video calls. A relative said, "The home do video calls so that we can keep in touch." Another relative explained they did not use this technology, so they welcomed telephone calls or letters from the service which kept them up to date with care home news generally and in contact with their relative.

● Electronic messaging systems were used to support people and their families to communicate during the pandemic. Staff supported people to use the technology needed to do this. A relative said, "They have organised (name of messaging App) so that families can be informed about what is happening there are two designated staff to manage it."

● The activities team, also often with the support of other staff, ensured people had organised activities to help them maintain their physical and mental wellbeing. We observed an activity where people with varying support needs conversed and played a game together, which they clearly all thoroughly enjoyed.

● Staff and managers were aware of those who found communal living challenging and who preferred generally not to take part in social activities. The risk of social isolation and loneliness in older people were known to the staff. One person said, "Some people I can't stand to listen to, the staff support me to get away. They know me. If I am feeling low, (member of staff) will talk to me. (Name of staff) is fantastic too. I feel cared for here."

Improving care quality in response to complaints or concerns

● There were procedures in place for complaints to be raised and for these to be responded to. A relative said, "I know how to complain if I had to, but I have no concerns."

● Complaints received were recorded on the service's 'complaints and compliments' record. We reviewed these records and the complaint responses provided which had been recorded, along with any subsequent actions which had resulted from the issues raised. The satisfaction of the complainant had also been sought and recorded where this had been possible.

● There were arrangements in place for people to give feedback, positive or negative. A form had been devised to enable people and relatives to do this called the 'critical friend'. Managers were keen for people

or their relatives to give them feedback, so if they had concerns, these could be proactively addressed and resolved before the complaints process needed to be used. We saw examples of 'critical friend' forms and we discussed with managers the action taken in response to one piece of feedback where the relative felt there could be an improvement. A relative said, "Any concerns have been addressed immediately." This form had been used to record positive feedback given over the telephone, to managers, by a healthcare professional.

End of life care and support

● People's frailty was monitored, and staff ensured people's ongoing care and treatment wishes were explored, including their end of life wishes. People's care and treatment wishes in relation to COVID-19 were recorded for staff reference; ReSPECT records were kept updated.

● When caring for people who were physically approaching the end of their life, staff ensured reviews were maintained with GPs. When supporting people who had COVID-19 and who were at the end of their life, GPs had been supported to speak with people virtually, about their treatment preferences.

● End of life medicines were prescribed in case they were needed by the nursing staff to keep people comfortable. Staff worked closely with pharmacies to ensure these medicines were in stock, in the care home, and available for when they may be needed. There had been no problems in accessing these medicines during the pandemic.

● Arrangements had been maintained, during the pandemic, for relatives to safely visit if their relative was at the end of their life. Relatives who had been unable to visit or who did not want to physically visit during the pandemic, had been supported to be with their loved ones, virtually, at this time by using technology for video calls.

● Staff worked with funeral directors to ensure the body of a deceased person was treated with dignity.

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.

At the last rated inspection this key question was rated as Requires Improvement. At this inspection this remained the same. Although the overall management of the service had improved, resulting in improved standards of care for people, further improvement was needed to ensure, the provider's monitoring system identified gaps in process and practice such as those identified during this inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the last inspection on 3 August 2020 this key question was inspected but not rated as we only looked at parts of the key question which had been of concern. We found some improvement to the provider's quality monitoring systems, although these had not been enough to enable the provider to assess the service's performance against, current best practice guidance and agreed pathways of care. This was a repeated breach of Regulation 17 (Good Governance) and the Warning Notice remained in place. The provider kept inspectors informed of the action being taken to address this.

Enough improvement had been made at this inspection to meet the Warning Notice and the provider was no longer in breach of regulation 17.

● Time was still needed for the provider to ensure their quality monitoring processes were effective in always identifying areas for improvement. The provider had not identified through their own quality monitoring processes the shortfalls we identified in relation to, people's behaviour support plans, anticoagulant risk assessments and Covid-19 risk assessments. They had not identified that all medicines errors had not been addressed appropriately and that COVID-19 staff testing had not been reviewed promptly when national guidance changed.
● During the inspection, when these shortfalls were pointed out, the managers acted immediately to address these. However, the provider's own quality monitoring system needed to be more effective in maintaining compliance, and comprehensive enough to identify all areas for ongoing improvement which promotes safe and best practice.
● The registered manager had introduced a clear management structure which supported a 'whole home' team approach to quality performance and risk management. Senior staff had been empowered and were supported to act on and resolve issues in their departments, to cascade necessary information and guidance to their teams and contribute to the service's overall management and monitoring processes.
● Improvements in leadership, processes and communication had resulted in better outcomes for people. The new care monitoring system allowed managers and senior staff to monitor the care provided to people. This system was also addressing the previously required improvements needed to the care records. It provided a structured format for staff to follow when formulating care plans and risk assessments. The system prompted staff for necessary information which could then be added to the system. Specific risks, such as those associated with anticoagulants, flagged up within the system for staff to see. The work of

transferring all care records to the system was still in progress, but we could see the improvement this was already making in terms of care delivery and the recording of the care delivered.
● An electronic messaging service was also used to keep all staff up to date with changes in people's condition and to direct care staff where they were needed. One nurse told us they did not now need to waste time trying to find staff when they needed them, as they just messaged them, and staff responded.
● Actions taken in relation to people's care and treatment, including those following accidents such as falls, were reviewed during the weekly clinical review meeting, which the registered manager attended. This ensured the correct action and follow up had taken place and ensured the actions in place, remained effective. The registered manager had full oversight of people's care needs and the risk management actions in place and could make changes to these when needed.
● A tracker tool was used by managers to monitor the progress of people's clinical needs such as their weight, falls, skin condition and wounds. We observed this tool being updated during a clinical review meeting. At an easy glance, managers could track people's progress and follow up on areas of clinical concern. The tracker tool had been frequently shared with us since the last rated inspection (November 2019) as part of our ongoing monitoring of the service.
● A full program of provider audits was in place. This included the auditing of people's care records, medicine administration records, health and safety checks and cleaning and infection control arrangements. Information from these audits informed the service's quality improvement plan (QIP). The QIP recorded actions for improvement. It also recorded the time frame given for completion of actions and who was responsible for completing these. This was a dynamic record which was updated to show actions completed and actions in progress. The QIP also contained all ongoing refurbishment and maintenance plans. Both the registered manager and the provider had full oversight of the QIP and its progress.
● An audit was also completed, by an external senior member of staff, on behalf of the provider (when travel during the pandemic and visiting to the home was permitted). This audit looked at all main areas of service and care and provided a report to the provider. Any actions resulting from this audit also informed the QIP.
● A tracker tool was also used to monitor completion of staff training, staff supervision and complaints management.

Working in partnership with others
● In November 2019, inspectors identified that the service needed to follow recognised and locally agreed pathways of care. Pathways of care ensure the involvement and working together with specialist healthcare professionals. They ensure a mutually agreed approach to a person's care and treatment, which is underpinned by evidence based best practice.
● There had been improved working with many professionals where an agreed pathway of care was followed by all. This had resulted in appropriate referrals to occupational therapy teams for equipment assessments, dieticians for dietetic support and joint working with tissue viability specialists and continence support services to improve outcomes for people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager, along with the Nominated Individual, shared the provider's vision which was "To provide the best possible care." The care home was part of a luxury retirement community and shared its facilities. There was a person-centred approach to care, which recognised people's differing needs, abilities, preferences and wishes.
● Since the last rated inspection, a stronger and more positive staff culture had been developed. Both managers had an inclusive style of working and had developed and nurtured ways of supporting staff. They had focused on team working and a 'whole home' approach towards supporting people. A member of staff told us the service's vision was, "To look after the residents in the best way possible and give them the best

person-centred care. It is the residents' home and they need to be in control." A relative said, "(Name of manager) wants the best for all residents" and another said, "I think they are doing their absolute best; communication is much better. They put family and residents first."

● Good outcomes for people had been achieved. This was evident from the improved processes used to monitor people's health and care, from the care delivered and from relatives' feedback. One relative said, "They have certainly stepped up, we can see improvements." One person said, "I'm not just saying it for your attention, I would say this to anyone. I am the happiest I've ever been here. I can't fault the staff, (name of registered manager and Nominated Individual) are fantastic and caring. They have really looked after me."

● Arrangements were in place to celebrate staffs' achievements and commitment and to show staff they were valued. Staff were nominated for awards, by other staff, people and relatives. These awards recognised acts that had resulted in a positive outcome for people or the service overall. The rainbow award recognised acts of caring and compassion towards people and the employee of the month award recognised an act which was above and beyond what would be expected. Four nominees had also been chosen and put forward for the Great British Care Awards.

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

● During the pandemic, managers had adopted creative ways of engaging with people's representatives and relatives. The use of regular video calls, electronic messaging and giving relatives their mobile telephone numbers had meant there were several ways for relatives to give feedback. The 'critical friend' form also contributed to the process of giving feedback.

● In 2020 the service had started a 'wishing tree'. People had been asked to make a wish and several were granted resulting in a positive impact on people. Members of the public, local businesses and services, including well known celebrities, had contributed to making a person's wish come true. Compliments received were record showing there had been much support and appreciation for this initiative. This initiative was continuing in 2021 and people had been discussing their wishes with staff.

● Displayed in a prominent place were actions taken in response to feedback given in the last 'residents' meeting (January 2021) and last staff meeting. The format, 'What You Said' and 'What We Did' was used to tell people and staff what actions had been taken in response to their feedback. This had included looking at more personalised activities, people's involvement in reviewing the menus, the introduction of laundry tags to reduce missing laundry, improvements to the headphones used for relative visiting and organising access to the virtual church service on both care floors instead of just one.

● Planned presentations to people, by staff in different departments, had started. These were designed to give people more insight into the work of each department and their involvement in people's support. They provided opportunities for people to meet staff they would not normally meet and to ask them questions and offer feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Managers were aware of their responsibilities regarding duty of candour and they promoted a culture where staff were encouraged to share, or report concerns or mistakes.

● Arrangements were in place to openly share with people and their relatives when things had not gone to plan, to offer an apology and to let them know what action had been taken to address things.

● Feedback from relatives confirmed they felt reassured that managers were open and honest with them. When asked about the management of the service, a relative said, "The care home would contact us if there were anything wrong at the home or with mum." Another relative said, "If they have not got the information I ask for at the time, they would come back to me with it."

Continuous learning and improving care

● The registered manager was keen to use feedback, complaints and errors in practice as ways of learning so improvements in care and the service generally could be achieved.

● The managers' and staffs' own experience and learning from managing COVID-19 and supporting people through this had resulted in a service which was able to confidently and successfully support a large number of people from another service who were in crisis from COVID-19.

● Learning had been derived from the previous areas of non-compliance and during this inspection, we saw a more mature service which had improved its standard of care and service to people since the last inspection.