Barchester Healthcare Homes Limited

St Thomas

Inspection report

St Thomas Close
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Thomas is a nursing home providing personal and nursing care to up to 72 people who have a range of needs, including diabetes, restricted or limited mobility, end of life care and mental health and people living with dementia. At the time of the inspection 60 people were using the service.

The home is a large two-story building. The ground floor comprised of people's bedrooms and communal spaces such as lounges, dining areas, and a hairdresser and barber area which were all centred around an internal courtyard. There was also a chapel situated off the main entrance to the home. The upper floor of the home primarily accommodated people's bedrooms and there was a lift between the two floors, which people could use to access the communal areas on the ground floor. Both floors offered communal bathrooms and toilets and all bedrooms offered en-suite facilities of either a bath or shower.

People's experience of using this service and what we found
There were appropriate numbers of staff deployed to meet people's needs. However, we received a high volume of feedback from relatives, professionals and some staff that staff were not always accessible or visible, particularly in communal areas of the home. Staff worked hard, however some staff felt they were not always able to respond to people's needs at the time they requested it. People were supported to receive their medicines, however some aspects of medicines management required improvement to ensure people were consistently supported in-line with the prescriber's guidance. There were clear safeguarding systems in place and people were protected from the risk of harm. Risks to people were identified, and there was guidance for staff to follow to keep people safe.

The home accommodated a large proportion of people living with varying stages of dementia. The environment was not always conducive to meeting their needs and national guidance to support people living with dementia had not been consistently incorporated. For example, there was a lack of accessible signage and use of colour to support people's orientation. People's care plans included a range of monitoring tools and best practice guidance; however, we could not be assured peoples oral hygiene was always managed in-line with best practice guidance.

Where people were assessed as lacking capacity to make specific decisions, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Systems and processes in place to monitor and improve service delivery were not always effective. The provider used a range of tools and audits to monitor the care people received, however they had not identified the issues we found at this inspection. There was a clear leadership team in place and staff knew where they could access advice and support. The registered manager was passionate about people's outcomes and knew people's needs well, however we received mixed professional feedback that the service consistently well-led.

People and their relatives told us staff were kind and caring. We observed staff treated people with respect and dignity and offered people choices throughout their day to day routines. People were supported by staff who knew them and their needs well. Staff understood the importance of maintaining people's independence.

People had opportunities to engage in a range of activities. People were supported by dedicated activities staff to engage in meaningful activities based on their interests. People's care plans were person centred, and captured people's likes, dislikes and preferences. There was a clear complaints procedure in place and relatives told us they felt comfortable raising concerns with the leadership team.

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

Rating at last inspection
The last rating for this service was good (published 09 August 2017).

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

Follow up
We will continue to monitor information we receive about the service until we 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?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

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.

St Thomas

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.

Inspection team
On the first day this inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the inspection was carried out by one inspector and one inspection manager. The remaining two days of the inspection were completed by one inspector.

Service and service type
St Thomas 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 unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including statutory notifications which providers are required to inform the CQC of, such as accident or incidents that have happened at the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with eleven people who used the service and six relatives. We spoke with the registered manager, and three members of the providers leadership team. We spoke with twelve members of staff including care staff, nurses, kitchen and maintenance staff. We spoke with four visiting professionals. We completed a range of observations around the home of people's engagement with staff. We reviewed a range of care records for people including care plans, risk assessments and medicines administration records. We reviewed staff files in relation to recruitment, induction and supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We sought feedback from the local authority commissioners and spoke with two social care professionals and two staff members.

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 inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant for some aspects of the service delivery there was limited assurance about safety.

Using medicines safely

● People were supported to receive their medicines from registered nurses. We reviewed a range of people's Medicines Administration Records (MAR) which nurses completed when medicines had been offered or administered. Records demonstrated people received their medicines as prescribed, with the exception of people's prescribed toothpaste. Although prescribed toothpaste was included on people's MAR charts, no records for its administration were in place. The provider could not demonstrate it had been administered in line with the prescriber's advice. The provider took immediate action to address this following our feedback and implemented a new recording tool.

● Two people were prescribed a transdermal patch, which is a medicated adhesive patch, placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream. Nurses used a body map to record which side of the body the patch had been placed. However, records did not always demonstrate new patches were applied in line with the manufacturer's guidance, to ensure they were not placed on the same area within a 14-day cycle. We found no evidence that harm had been caused and following our feedback the provider took immediate action to address this and implemented a revised recording tool.

● There were clear systems to ensure people's medicines were stored appropriately and in line with best practice guidance, which included staff completing daily temperature and stock monitoring checks.

● Where people's medicines were prescribed on an 'as required' basis such as pain relief and anxiety management, there were protocols in place for staff to follow to ensure people were supported to take these when needed.

Staffing and recruitment

● Relatives told us staff were not always easily available or visible, particularly in communal areas of the home. Comments included, "When I walk around I see things, sometimes you have a job to see a carer in [lounge areas] with people" and, "I've gone to help people on occasions, but I don't like to do so." One person told us, "[Staff] are always so busy, so they tend to rush you which I don't like."

● We found staff were generally visible and engaged with people. However, on one occasion we heard a person calling out for help from their room. We informed the registered manager who sought assistance for the person. We observed another person was provided with a drink in a communal lounge and then had to wait 15 minutes before care staff returned and supported them to drink it. The staff member confirmed the person required full assistance with drinking. We also sought assistance from care staff to support a person who left their bedroom and was in the corridor without lower clothing on. Staff responded and supported the person to cover with a towel and assisted them to their room.

● We reviewed a weekly record of call bell responses from February 2020 and found people's calls for assistance were responded to promptly by staff. However, staff commented, they were often busy, and it

could be an additional challenge to respond promptly to people living with dementia whose needs regularly fluctuated and often needed more time. Comments included, "Staffing levels are sometimes good, and sometimes we need more because of complexities of people and challenging residents. It can be difficult to give [people] the time they want and need at the time they want it" and, "Logistically it can be difficult [to monitor people]. On days where [people's behaviour] is heightened, I think there are enough staff but can be a fine line."

● The provider used their dependency tool to support them to calculate the required staffing levels for the service. We sampled weekly rotas from December 2019 to the point of inspection and found the staffing levels generally met the provider's dependency calculation. There was a system in place to deploy staff across the service and staff were designated areas of the home or tasks on each shift including hourly monitoring of people where required. Although both call bell records and staff dependency tools showed there were sufficient staff deployed. Feedback from both relatives and staff indicated it was a challenge at times for staff to meet people's needs, especially those living with dementia and they felt as a result people's care could be either rushed or as we saw delayed.

● There was a clear recruitment pathway for new employees. This included disclosure and barring service (DBS) checks for new staff before commencing employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working in health and social care. Where registered nurses were recruited, the provider ensured the appropriate checks were completed to confirm staff held the required professional registration with the relevant regulatory body.

Systems and processes to safeguard people from the risk of abuse

● Staff received training in safeguarding to support them to recognise and respond appropriately to signs of abuse. Staff we spoke with knew how to raise concerns with senior staff and the registered manager and were confident in the steps that they could take to keep people safe.

● There were appropriate systems in place to protect people from abuse. This included information sharing with the appropriate professionals such as the local authority to ensure people were safeguarded.

Assessing risk, safety monitoring and management

● Risks to people were appropriately managed. Risk assessments provided information for staff to follow and included the steps they should take to reduce or remove identified risks to people. For example, where people were identified to be at risk of developing pressure areas and of skin integrity breakdown, the information included peoples repositioning needs and what equipment they required such as pressure relieving mattresses.

● Environmental risks to people were managed. The provider took appropriate steps to make sure the building and equipment used were maintained in a safe way. There were regular maintenance and safety checks on equipment such as hoists.

● People had individual fire evacuation plans showing the support they would need in an emergency, this included information about the levels of support they required and and equipment they may need.

Preventing and controlling infection

● Staff had access to personal protective equipment such as disposable gloves and aprons. We observed staff used this appropriately during the inspection when supporting people.

● People's laundry was well managed to ensure risk of cross infection was reduced in-line with best practice guidance.

● There was clear delegation of cleaning tasks between the house-keeping staff and care staff, which was overseen by regular audits reviewed by the registered manager or senior staff.

Learning lessons when things go wrong

● The registered manager maintained oversight of all accidents and incidents that occurred at the home. This enabled them to identify potential patterns, themes or trends at the service and take appropriate action. For example, where people experienced multiple falls, records demonstrated the registered manager completed a monthly analysis of people's collated information and identified what steps had been taken to keep people safe.
● There were regular meetings with managers and senior leaders from the provider's other services to share information and advice, including any safeguarding learning and best practice examples.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider could not demonstrate people's oral health care was always effectively managed in line with best practice guidance. We received feedback from some relatives and professionals that some people's day to day oral health care needed to improve. Comments included, "We've seen three people this morning, and none of them have had their teeth brushed", and, "Sometimes I'm not sure [if loved one] has cleaned their teeth."
- We reviewed oral healthcare records and daily records of the care people received to manage their oral hygiene. People had oral health care plans in place which detailed the level of support they needed from staff to manage their oral hygiene. However, people's daily records did not specifically detail what oral care support and when, had been provided to people. We raised this with the registered manager who took immediate actions to address this.
- We saw other areas of people's care plans included effective use of best practice guidance. For example, people's needs were assessed using a range of nationally recognised assessment tools such as the Waterlow score. This assessment tool is used to estimate the risk of people developing pressure areas.
- People's needs for care and support were assessed prior to the delivery of their care. The registered manager or senior staff completed assessments with people and their relatives and other professionals where relevant to ensure they could meet people's needs before they accessed the service.

Adapting service, design, decoration to meet people's needs

- The service had undergone some redevelopment and decoration by the provider in 2019 which included creating an additional communal dining area and meal serveries. However, adaptations and design of the home did not consistently consider the needs or suitability for people living with dementia in-line with the department of health's national guidance. A relative commented, "It's a lovely building but not for the purpose it's used for."
- There was a lack of accessible signage to support people living with dementia to orientate around the home. Signage was not high contrast and did not use pictorial ques. Colour schemes were used throughout the home, however, these were not high contrast and did not promote doors and hand rails being easily identifiable to people. We raised this with the registered manager who told us the provider's internal dementia specialist team were due to review the environment in the coming months.
- People's rooms were personalised with their belongings such as pictures and ornaments.
- The home offered a range of communal areas and lounges which people could access. Where people's rooms were situated on the upper floor, there was a lift in place to enable people to access the communal areas on the ground floor if they wished.

● People had access to a communal garden area. The gardens layout and design was supportive of people's needs and included appropriate areas for seating and raised flower beds to promote accessibility.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.

● Good professional relationships were not always consistent. We received mixed feedback from professionals that the communication of people's needs supported effective partnership working. For example, one professional commented, "Referrals are made OK, but information and communication can be poor", and another professional told us that information sharing was not always consistent, "especially at weekends or evenings" when particular members of the senior team may not be available. Whereas another professional said, "I was really impressed with the documentation, everything I asked for could be provided."

● We reviewed a range of care records and found where advice was given by professionals, this was recorded for staff to follow. Staff were also kept updated on any changes or new professional advice and guidance through regular shift and daily hand over meetings led by senior staff.

● Where people required input from other professionals, records demonstrated appropriate referrals were completed. For example, people's records included referrals to speech and language therapists, dentists, GP's and opticians where appropriate.

Staff support: induction, training, skills and experience

● Staff had completed a range of training to support them in their role. This included safeguarding, moving and handing and modules focused on working with people with dementia.

● We noted staff frequently supported people with end of life care. Registered nurses received training in clinical aspects of end of life care, such as methods of pain management. The service was exploring further training options which reflected best practice principles for all care staff. Resources were available for care staff in the interim.

● Newly recruited staff were supported through a planned induction programme. This included completing a range of training and provided staff with opportunities to shadow more experienced staff. We spoke with a staff member who told us they found the induction programme helpful and supportive.

● Staff rotas demonstrated a good skill mix of staff and senior staff including registered nurses and management were deployed daily. This meant people and staff could access advice and guidance from experienced staff.

● Records demonstrated staff received regular supervision. We spoke with staff who told us they found supervisions supportive. However, we noted the duration of some people's supervision was short and followed a set structure rather than allowing staff to identify their own areas for discussion and learning. We discussed this with the registered manager who advised there was an open-door policy and staff could access advice and guidance at any team from the senior team.

Supporting people to eat and drink enough to maintain a balanced diet

● People's diet and nutrition needs were met. Where people had prescribed dietary needs such as modified diets recommended by a speech and language therapist, information was clearly recorded in their care plan and effectively communicated with kitchen and care staff.

● People's choices were promoted. People were offered a choice of meals and their preferences were known and accommodated. Staff presented people with plates of the options available at each meal, to enable them to see what was available and to make their choice. People were given the choice of where they would like to eat their meals and could choose to eat in the privacy of their room or opt to eat socially in the dining areas of the home.

● People had access to snack baskets which were regularly replenished and placed in the communal areas

of the home. We observed people could help themselves and foods included fruit, crisps and chocolate bars.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Where people had been assessed as lacking capacity to consent to their care and accommodation, records demonstrated the registered manager made relevant applications to the local authority. This ensured where people's inability to consent to their living arrangements had the potential to deprive them of their liberty, the appropriate authorisations were in place.
- Where people had elected important people in their lives, such as relatives to act as power of attorney, this information was included in people's care plans.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff had established positive relationships with people. People told us staff were caring their comments included, "[Staff are] ace, I get on well with the staff", and, "[Staff are lovely, they are kind. They look after me very well, nothing is too much trouble."
- Relatives told us staff treated their loved one's with kindness. For example, one relative said, "I find [staff] very good. Always pleasant. To me they have always been very good." Another relative said, "[The registered manager] told me I could have a relationship with [loved one] here without the worry and they are right."
- Staff knew people and their needs well. Staff we spoke with talked about people and their needs with care and compassion and could confidently explain how they met people's care and support needs.
- People's care plans captured information about their cultural, spiritual and religious needs. People could access the on-site chapel and the activities staff had made contact with local faith groups to explore if visits to the home could be accommodated for people.

Supporting people to express their views and be involved in making decisions about their care

- People and relatives were supported to share their views on the service through planned resident and relatives' meetings.
- The service held weekly multidisciplinary meetings with other key professionals such as the GP, pharmacy and clinical commissioners. The registered manager discussed how this provided people and their relatives with opportunities to speak with a range of professionals during planned reviews of people's health and care needs. A relative we spoke to confirmed this and said, "I had to opportunity to meet [loved ones] GP a few weeks ago."
- We observed staff regularly engaged with people to offer choices around their care and support throughout the day. This included choice of activities, food, drinks and where and how they would like to spend their time.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity were respected. Staff used flexible approaches to support people to receive their care in a dignified manner. For example, we observed staff support a person by using a portable screen when they did not wish to leave a communal area. This enabled the person to have their dental check-up and avoided causing anxiety or distress to the person.
- People could opt to spend time in the communal areas of the home, however people could also spend time in their room if they sought privacy. To support people to maintain their privacy, staff completed regular checks on people where this was necessary to keep them safe.

● Staff understood the importance of encouraging and maintaining people's independence. Staff explained how they supported people to remain as independent as possible, such as encouraging people to complete tasks of personal care where they were able. One staff member commented, "Independence is also about encouraging people to think for themselves, empowering them, people can be happy to sit there but it's important to give gentle encouragement and options."

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 good. At this inspection this key question has remained the same. 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

- People's care plans were person centred and contained detailed information of people's needs and approaches staff should take to support them.
- People's care plans included information on their life history such as previous employment, achievements, relationships, and things that were important to them. This supported staff to engage with people in meaningful ways. For example, where a person had previously worked as a hairdresser, staff created an activity where the person was supported to be able to wash and dry the staff members hair in the on-site hairdressers.
- In addition to their care plans, people had a "This is me" booklet to capture personalised information on things that were important to them, their likes, dislikes, hobbies and interests. We reviewed three people's booklets and found the level and detail of information recorded was varied. We discussed this with the activities co-ordinator who told us they were currently working with people and their relatives to capture more detailed information. We saw this issue was discussed at the relatives meeting during the inspection.

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 care plans included information on their individual communication needs and the approaches staff should follow to support people to engage.
- However, we noted the service did not have accessible complaints information such as an easy read procedure for people using the service. We raised this with the registered manager who told us they would review and action this following our feedback.

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 opportunities to engage in a range of planned activities in the home in keeping with their interests. Activities included arts and crafts, knitting groups, exercise sessions and table top games. Where relatives were visiting, we saw they were encouraged to join in with their loved one during the sessions.
- Activities were scheduled daily and included group sessions people could join and one-to-one sessions for people, such as those who were cared for in bed or remained in their room.
- We observed a range of activity session's during the inspection and found people had a positive relationship with the activities co-ordinator. We saw people were offered choices of what they would like to

do, and group activities created a social atmosphere where people and staff chatted about things of interest to them.

● The activities co-ordinator spoke passionately about the benefits of people having a meaningful structure to their day. They discussed how they were working to build community links to offer people new experiences and activities. For example, they had recently planned a cooking session to take place where people could participate in cooking and baking.

● The provider had invested in technology via an interactive game's projector. The registered manager told us this enabled people with varying abilities to access and participate in table top games or sensory sessions with each other or their loved ones.

Improving care quality in response to complaints or concerns

● Relatives we spoke with knew how to raise concerns. For example, one relative said, "I would speak to [registered nurse] or the assistant manager or the registered manager. A couple of the girls are especially helpful."

● We reviewed records where concerns and feedback had been raised. These were appropriately recorded and demonstrated steps that had been taken to respond to people's feedback.

End of life care and support

● Where appropriate and people expressed a wish to remain at the service to receive end of life care this was captured in individual care plans. People's care plans also included information on things that were important to them, such as relatives they would like informed or involved in their care planning, any religious or cultural beliefs they held and details on particular funeral arrangements in place.

● There were systems in place to ensure people had access to the right support at the right time to meet their end of life care needs. For example, the home met weekly with a range of healthcare professionals including GPs where advice and guidance could be sought, including ensuring people had anticipatory medicines in place as appropriate to support them to have a dignified and pain free death.

● The registered manager spoke passionately about the support that the home provided to people and their relative to ensure they remained settled and in a familiar environment where this was their wish to do so.

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 inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the systems and processes in place to monitor, review and drive improvement were not always consistently managed.

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

● Systems and processes to monitor service delivery were not always effective. The registered manager and delegated staff completed a range of audits; however, these were not always robust.

● Regular audits were completed around the storage, administration and stock of people's prescribed medicines. We found systems in place did not ensure adequate oversight of records in relation to the positioning of people's transdermal patches and the administration of prescribed toothpaste, to ensure they had been administered correctly. However, where audits of people's other prescribed medicines were completed these were effective. For example, staff completed regular medication stock checks and temperature monitoring of where medicines were stored.

● Regular audits of people's care records were completed. We found these were not always effective in ensuring information was updated across the range of people's individual care plans. For example, for one person we saw information in their care plan directed staff to complete repositioning three hourly and other records identified four hourly repositioning. We also found some people's needs assessments using the provider's dependency tool were not always accurately assessed or updated in line with the provider's guidance. As the provider used this tool to assess and anticipate adequate staffing levels, this meant there was a potential risk that staffing levels were not always reviewed against accurate and up to date information. We found no evidence that people had come to harm as a result of the issues identified. The registered manager took immediate steps to address this.

● Where audits identified actions, we found most actions were completed in a timely manner. For example, where regular checks of fire equipment identified maintenance was required, this was completed. However, where an internal audit completed by the providers quality team in January 2020 identified not all reported incidents had been appropriately escalated outside of the organisation, this action was incomplete.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager and senior staff were passionate about the people they supported. The registered manager knew people and their needs well and staff told us they were regularly visible in the service. This included regular walk-arounds and engaging with people, professionals and relatives.

● Staff were supported through the clear delegation of tasks and knew who they could seek advice and guidance from. This included senior care staff, senior nurses and the deputy and registered manager. Staff told us they felt confident raising queries or concerns with the registered manager. Comments included, "I would go in [to the office] if I had any concerns. We also let nurses know if we have any concerns, such as

any wound care we notice and without a doubt they follow it up."

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

● The registered manager understood their duty of candour requirements. The duty of candour sets out actions that the registered manager should follow when things go wrong, including making an apology and being open and transparent. We reviewed records which demonstrated the provider followed their policy and took all necessary actions when this was relevant.

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

● Some relatives told us they felt their feedback was not always acted upon, we discussed this with the registered manager and actions had been taken in line with the providers complaint's procedure, however we noted actions taken had not been recorded.

● The registered manager chaired a range of meetings to support people, their relatives and staff to share their views. Meetings were held regularly and we saw people's ideas were considered and implemented where possible. For example, bird seed balls were introduced in the gardens following relative feedback that people enjoyed this activity.

● Relatives told us they had good communication around their loved ones care and support needs. For example, the registered manager or senior staff regularly updated relatives if their loved ones need's change or there had been an incident such as a fall. A relative commented, "[The registered manager] is available if you want to see them. I like [the registered manager]. [Senior] staff here have been very good and supportive to me."

● Activities were used to support people to stay connected with their local communities. For example, a local school visited the service regularly for activity sessions. The activities were also in the process of exploring other ways people could feel connected to local groups.

Continuous learning and improving care

● The provider had a range of internal resources available to support the development of their services. These included clinical governance leads, dementia specialist resources and quality monitoring. The provider used internal bulletins to share key information or changes across services.

● The provider promoted opportunities for information to be shared across their services. This included information on best practice, lessons learnt and skill and knowledge sharing through regular leadership meetings. The registered manager told us they could access support, advice and guidance from these resources. For example, the registered manager discussed how they had been able to seek advice on pressure care for a person from the clinical team which gave opportunities for fresh eyes and ideas and knowledge sharing.

●The registered manager completed a root cause analysis or reflective records following incidents at the home. This enabled them to review actions that worked well or needed to be improved.

Working in partnership with others

● We received mixed feedback from professionals that the service worked in partnership well with other services. For example, one professional commented that they felt senior staff were not supported in their role to make decisions by the leadership team. Other professionals told us they found interactions were open and honest and one professional commented, "We found [The registered manager] to be very accommodating and professional."

● We discussed this feedback with the registered manager who told us they had not been approached by professionals raising any query or concern. They told us they valued professional relationships with other

organisations and would continue to promote multi-agency working to benefit outcomes for people.

● The service engaged in opportunities to work with other professionals and organisations. This included weekly reviews with a range of healthcare professionals to review people's needs. Staff spoke positively about the opportunity to share knowledge and seek advice and guidance on meetings people's needs.