Sovereign (Coxwell Hall) Limited

Coxwell Hall and Mews Nursing Home

Inspection report

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Date of inspection visit:
14 March 2016

Date of publication:
26 April 2016

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

We inspected this service on 14 March 2016. This was an unannounced inspection. Coxwell Hall and Mews nursing home is registered to provide accommodation for up to 59 older people living with dementia who require personal or nursing care. At the time of the inspection there were 56 people living at the service.

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

People who were supported by the service felt safe. The staff had a clear understanding on how to safeguard the people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines. However, there was no clear guidance for people using thickener where choking was a risk.

People at risk of developing pressure sores were not always protected from these risks. People's pressure mattresses were not always set to correct pressures.

The provider had an infection control policy in place. However, people were not always protected from the potential risk of infection. Staff wore long sleeved clothes whilst delivering care as well as handling food.

There were enough suitably qualified and experienced staff to meet people needs. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. However, the registered manager did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of MCA. The registered manager relied on capacity assessments carried out by other health professionals.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People's nutritional needs were met and people had a good dining experience. People were given choices and received their meals in timely manner. We observed people during lunch time and saw people being supported with meals in line with their care plans.

People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they cared for.

There was a calm, warm and friendly atmosphere at the service. Every member of staff we spoke with was motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

People had access to activities and stimulation from staff in the home. Activities were structured to people's interests. We observed people engaged in arts and crafts, ball games and cake baking.

The registered manager used best practice guidance in dementia care. For example, the butterfly scheme was used in the home and all staff had an awareness of it. This is a scheme used to improve the wellbeing of people with dementia. Staff discussed how to best support people and what activities and changes to the home would suit the needs of people.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

The registered manager informed us of all notifiable incidents. The service had quality assurances in place. However, these quality assurance systems were not always effective. The registered manager had a clear plan to develop and improve the home. Staff spoke positively about the management and direction they had from the manager. The service had systems to enable people to provide feedback on the support they received.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risk of choking. The service did not always protect people from risk of infection. The equipment used for prevention of pressure sores was not always set correctly.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Arrangements for medicines were in place to ensure they were administered safely and stored appropriately by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager did not have a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of the MCA.

People who were being deprived of their liberty were being cared for in the least restrictive way.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their

care.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service and visiting professionals spoke highly of the staff and the care delivered.

Is the service responsive?

Good

The service was responsive.

People received activities or stimulation which met their needs or preferences.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's care plans were current and reflected their needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality and safety of the service and drive improvement. However, these were not always effective.

Staff spoke positively about the team and the leadership. They described the manager and other senior staff as being supportive and approachable.

The leadership throughout the service created a culture of openness that made people feel included and well supported.

Coxwell Hall and Mews Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 March 2016 and was unannounced. The inspection team consisted of four inspectors, a specialist advisor in the care of people living with dementia and an expect-by-experience in the care of people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from three social and health care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We obtained feedback from commissioners of the service.

We spoke with seven people and three relatives. We looked at twelve people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the area manager and nine staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with

people and staff, incident reports, complaints and compliments. We reviewed feedback from people who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 11 July 2014, we found medicines were not always managed safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which is the equivalent of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in March 2016, we found improvements had been made. Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescriptions. Staff kept an accurate record of people's prescribed medicines. Where people had limited capacity to make decisions about their own treatment, the service followed the correct procedures when medicines needed to be given to people without their consent. For example, one care record stated how the covert medicines were to be given. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why.

However, we found additional concerns in relation to the management of thickening agents. A thickening agent is prescribed for a person where they have swallowing difficulties or are at risk of choking. For example, one person's care record stated the consistency of the thickener required was two scoops per 100mls of fluids. The speech and language therapist (SALT) guidelines recommended that the person had fluids of a 'double cream consistency'. The copy of the SALT guideline was not in the person's care plan but archived in a filing cabinet. Another person's care plan stated they were having a soft diet. They had been prescribed a thickener by the GP but there was no record of fluids requiring thickening. There were no SALT guidelines on file and the dietary requirement file stated they were on normal fluids. One member of staff did not know the person required their drinks to be thickened. We discussed these concerns with the registered manager and some of the plans were updated by the afternoon on the day of the inspection.

People who were at risk of developing pressure sores had appropriate equipment in place which included pressure relieving mattresses and cushions. However, the pressure mattresses were not always set to the correct pressures. For example, one person weighed 51.4kgs but their pressure mattress had been set at a setting suitable for a person weighing 100kgs. We checked three more people's mattresses and none were set to the correct pressures for that person's weight.

The provider had an infection control policy in place. Staff understood their roles and responsibilities for maintaining standards of cleanliness and hygiene. We observed staff washing hands appropriately and using protective equipment effectively. Infection control was embedded in the service's mandatory training with yearly updates. Staff wore their own clothes rather than uniforms. The registered manager told us this was to show no sign of authority and make people more comfortable with staff. However, we observed four members of staff wearing long sleeved clothes and delivering care as well as handling food. This was a potential infection prevention risk. We discussed these concerns with the registered manager who assured us this would be addressed as a priority.

Following our visit the manager told us all these areas had been actioned. However, we have asked the provider to forward an action plan to demonstrate continuous improvement as these concerns had not

been identified by the provider prior to our inspection.

These concerns were a breach of Regulation 12 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Equipment used to support people's care was clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, safety checks were conducted by staff. Records showed risk assessments had been completed for the use of bedrails. We observed staff used equipment correctly to keep people safe.

People told us they felt safe and supported by staff. One person told us "It's safe. There are no problems". Another person said "I am safe here. I like it". Relatives told us they felt the service was safe. Comments included, "I feel my mum is safe here" and "Oh yes, very safe. No problem. I have not seen anything to worry me at all". One professional told us, "This home has a security system which comprises of key pads for staff and visitors to enter".

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us if they witnessed any abuse in the home, they would inform outside agencies such as the Care Quality Commission (CQC) and the local authority safeguarding team. We saw Oxfordshire 'Safeguarding Adults' information displayed in the registered manager's office.

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person had unpredictable behaviour that challenged and could have posed a risk to themselves and others. The person's care record contained a risk assessment that required staff to monitor the person every fifteen minutes and informed staff to support the person on a one to one basis when they were exhibiting challenging behaviour.

People were supported by sufficient staff with the skills and knowledge to meet their individual needs. Staffing levels were determined by people's assessed needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The manager considered staff sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. Staff comments include, "We used to have some agency but not now. There is always a registered nurse on each floor" and "I think we have enough staff. In the event of staff sickness, the nurse in charge would cover".

Safe recruitment procedures were followed before staff were allowed to work at Coxwell Hall and Mews care home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. 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. However, the registered manager did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of MCA. The registered manager relied on capacity assessments carried out by other health professionals.

This was a breach of Regulation 11 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the registered manager told us the provider had sourced support and guidance in line with completion of mental capacity assessments and planned to have these completed within a month. However, we have asked the provider to forward an action plan to demonstrate continuous improvement as these concerns had not been identified by the provider prior to our inspection.

People's consent was always sought before any care or treatment was given. We observed staff knocking on people's doors and seeking verbal consent whenever they offered care interventions. One member of staff told us, "People have choices and I ask for their consent before I give care". Another member of staff said, "All the time we talk with people and try to explain care to be provided". We saw in care files that people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files reviewed showed consent for taking and using photographs.

Staff had a good understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. Where people were assessed as lacking capacity and a DoLS had been authorised they were supported in line with the DoLS. The registered manager had a clear understanding of their responsibilities in relation to DoLS.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. Staff comments included, "I had a period of shadowing when I was just looking", "Induction was very good and included roles and responsibilities" and "Induction prepared me fully for my role".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, staff had completed training in dementia care. Staff told us they had the training to ensure they had the skills and knowledge to meet people's needs. We observed staff were aware of people's needs and had identified the need for more training in end of life care. The registered manager told us this was being arranged for all staff across the board. The registered

manager said, "I like to see my staff developing".

Staff were supported to improve the quality of care they delivered to people through supervision (one to one meeting with their line manager) and annual appraisal. Staff comments included, "We have supervisions every two months", "They ask me if I am happy and what improvements to make" and "I had my supervision with the nurse and this was helpful". Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process. Records showed staff had requested more training in dementia care and this was planned to be delivered in the week following our inspection.

Kitchen and care staff had the information they needed to support people. Some people had special dietary needs, and preferences. For example, people having softened foods or thickened fluids where choking was a risk. However, these specific dietary needs were not always met. The home contacted GP's, dieticians and speech and language therapists if they had concerns over people's nutritional needs. Four people had been referred to speech and language therapists for guidance. However, the guidance provided was not always followed through.

We observed snacks were available for people throughout the day, such as fruit, cakes and biscuits. One person's relative told us their relative was refusing to eat and drink and staff always encouraged them. The relative said, "They (staff) are always bringing her drinks and trying to get her to eat". People told us they enjoyed the food. Comments included, "I always enjoy the food", "I get the food that I ask for" and "Look, we all finish our food. I can have more if I want". Where some people had lost weight there was a plan in place to manage weight loss.

We observed one member of care staff who supported a person to eat their meal which was in line with their care plan. The member of staff supported the person at a pace that suited the person and let the person assist themselves as much as possible. Another person's care record stated, 'Needs prompting during meals as can walk away and forget his meals and is able to pick a meal if presented with a choice through pointing or taking meals'. We saw staff giving this person a choice of meals and the person taking the meal they had chosen. We observed staff prompting the person to eat. This showed us staff understood the needs of people they supported. We saw some good practice, for example, there was a chair for a member of staff to sit and eat with people at each table. During lunch time we saw people received their food in a timely manner.

People had regular access to healthcare professionals such as, chiropodists, opticians, community mental health team, GP, care home support team and dentists. People were referred for other specialist advice. For example, from the speech and language therapist (SALT) if they were thought to be at risk of choking or the falls team for issues with mobility. Professionals told us they were notified of people's changing needs. One professional commented, "Any recommendations we have made, have been quickly responded to".

People could move around freely in the communal areas of the building and gardens. There were several sitting rooms, the quiet room, activities room and garden areas, which gave people a choice of where to spend their time. Most of the home's areas were decorated in a way that followed good practice guidance for helping people with dementia to be stimulated and orientated.

Good

Is the service caring?

Our findings

Most people in the home could not communicate verbally due to their condition. However, people that were able to speak with us were positive about the care they received. One person said, "It's a good home. We are all friends". Another person told us, "Yes staff are caring". Relatives also spoke positively about the home and the care their relatives received. One relative told us, "Staff are lovely and caring". Another person's relative said, "Staff are excellent, very caring and compassionate". We also received many positive comments from social and health care professionals. Comments included, "The staff are kind and considerate towards the residents and they are patient with them", "Every time I have been to this home the staff have been very caring towards the patients and welcoming to me" and "I have never heard any raised voices towards their residents".

We observed many caring interactions between staff and the people they supported during our inspection. People were relaxed in the company of staff. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. For example, one member of staff commented to a person who had just returned from the hairdresser, "I like your hair, it's nice". When the member of staff spoke she placed her arm gently around the person's shoulders. The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour throughout the day.

Staff had a caring approach to their work. Comments included, "I try to do my best. I like this job", "I like to work with old people because I have a grandma "and "It's more like a family, more flexible, there is no routine-we don't do routines". People recognised care workers and responded to them with smiles which showed they felt comfortable in their company. Staff took time with people. Tasks were not rushed and they worked at the person's own pace. The manager told us, "All staff are trained to care and clean".

People's bedrooms were personalised and contained photographs, pictures and the things each person wanted in their bedroom. People's doors were decorated like a front door, with a colour of their choice. Staff told us this enabled people to recognise their rooms. This also gave the feeling that this was the person's private room. There were photographs of people, memory boxes and short biographies with information about people's interests near their front doors.

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. This helped staff build positive relationships with people by communicating in ways that were appropriate to them. For example, we saw staff bringing a newspaper in the language of a person whose first language was not English. Staff told us they had got to know the person's way of communication and were able to understand when that person wanted something, was happy or sad. There was good communication between staff and people, and staff were knowledgeable of people's preferences. This showed people's individual needs were recognised and staff were able to care for people in a person centred way.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us they

would explain care to be given and seek the person's consent to ensure dignity was respected. Staff comments included, "Privacy is important and I understand that", "During personal care, we close doors and windows" and "I always knock on a door and remind carers to ensure dignity whilst washing the resident". People's records included information about their personal circumstances and how they wished to be supported. This allowed staff to plan the people's care and support them to maintain their independence regardless of their level of disability. Staff told us how they would let people do as much for themselves as they could with minimal support and prompting.

Staff understood and respected confidentiality. One member of staff told us, "I do not discuss care plans unless it's necessary". We saw records were kept in locked offices only accessible using a keypad.

People were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision. The service used a 'Thinking ahead document' to records people's future preferences. One person had a care plan record which showed they only wished to be admitted to hospital for fractures or haemorrhages and preferred to be cared for in the home if they were seriously ill. People, their families and professionals contributed to the plan of care so that staff knew people's wishes and made sure people had dignity, respect and comfort at the end of their lives. Relatives told us end of life care was provided in a compassionate and supportive way. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. Staff told us how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "We do 15 minute comfort checks for anyone on end of life care". We saw many thank you cards that showed relatives felt staff had demonstrated an empathetic and caring nature to people and their families during end of life care.

Good

Is the service responsive?

Our findings

Before people came to live at the home their needs had been assessed to ensure they could be met. These assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights.

Care planning was focussed on a person's whole life, including their goals skills and abilities. The provider used a 'This is me' document which captured people's life histories including past work and social life enabling staff to provide person centred care and respecting people's preferences and interests. People's care records contained detailed information about their health, social care and spiritual needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up. People and relatives confirmed they were involved in planning their care. One person's relative said, "I met with the nurse and discussed how to care for mum". The provider had a key worker system in place which gave people and relatives a point of contact, allowing consistency and the establishment of meaningful relationships.

Records showed staff treated details of what was important to each person living at Coxwell Hall and Mews nursing home as important information. This information was used to engage with people and ensure they received their care in their preferred way. For example one record stated, 'I easily get distracted during meals and forget to eat'. This was actioned as we saw staff prompted this person during their meal. Another record showed a person who was forgetful. It stated, 'I easily forget where I am and wander off. I may require redirecting'. We observed staff reassuring and redirecting the person throughout our inspection.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person had previously required a standing hoist but their mobility was deteriorating. The person had been reassessed and now required assistance with a full hoist. We saw the care plan had been updated to reflect the changes.

The provider employed an activities coordinator. The activity co-ordinator told us they had time to talk with people and their families to develop life history documents. They told us this helped them plan activities to meet people's needs. Staff understood the importance of involving people in appropriate activities which were stimulating and helped people to feel involved. Staff told us activities were based on people's preferences. Records showed there were one to one activities such as talking, jigsaws, reminiscence and arts and crafts as well as group activities. Records also showed people had been involved in several day trips. Other people preferred to remain in their rooms and staff respected that. On the day of our inspection we observed limited engagement in the Hall lounge. We discussed these concerns with the manager who informed us they were in the process on improving staff engagement through specific dementia training embedded in the butterfly scheme.

Feedback was sought from people through regular relatives and residents meetings as well as quality assurance surveys. Records showed that some of the discussions were around effective communication. For

example, at the last meeting it was identified how difficult it was to communicate and understand people living with dementia. As a result the registered manager had arranged for regular discussions during meetings about communications with people living with dementia for relatives. The registered manager had also provided people's relatives with hand-outs and DVDs on Dementia.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People's relatives commented that the manager 'Was easy to get hold of and responsive to concerns' .One person's relative told us they had raised concerns to the manager about their relative's medications and the manager had quickly arranged a meeting with the doctor and community practice nurse. Another person's relative told us, "Staff are very good when I raise any concerns".

Staff knew how to raise concerns. Staff comments included, "I would investigate the issue, inform the manager and log the complaint in the log book", "If I am worried about anything I can complain to the team leader" and "I will report to the nurse and the nurse will take further action".

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Requires Improvement

Is the service well-led?

Our findings

The service was managed by the provider and a registered manager who were supported by two unit managers. The registered manager had been in post for five months. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. There were a range of quality monitoring systems in place to review the care and treatment provided at the service. These included regular audits of medicine administration records, care plans, and gathering peoples experience of the service through satisfaction surveys and other feedback. Where any issues had been identified, an action plan was put into place to address them and this was followed up to ensure actions had been completed. However, these quality systems had not identified the concerns we found.

The manager had an open door policy, was always visible around the home and regularly worked alongside staff to deliver care. One person's relative said, "There is an open door policy". People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. People and relatives could drop in anytime to speak with the manager. The provider had facilitated a resident and relative survey. However, the results had not been analysed. We discussed this with the registered manager and they told us they were in the process of analysing the results. The service also did surveys which identified staff of the month as well as staff of the year. This was aimed to motivate staff in performing beyond their roles.

Staff were complimentary about the registered manager. Comments included, "Manager is supportive, understands me and helps", "The manager is very supportive, I feel supported", "Manager is always around. There is support and good team work" and "The manager is visible and supportive. Teamwork is superb and no one moans". Staff told us they felt valued and respected by the provider and registered manager. Staff told us their views were listened to and good practice was promoted.

Staff told us there was good communication between all staff within the home. Staff informed us they attended daily 'flash meetings' (daily meetings to discuss current issues within the home). Staff said these meetings gave them current information to continue to meet people's needs. One staff member said, "We have daily handovers. It's good information sharing". The registered manager told us they encouraged staff to give their views during handovers.

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff were involved in discussion about how to improve people's care and encouraged to give their views.

Coxwell Hall and Mews was accredited through the butterfly scheme. This is a system used to provide good practice guidance around dementia care as well as improve people's well-being. This guidance was available for both staff and people's relatives. The butterfly scheme supported a person centred culture. The registered manager promoted a positive culture on dementia care through the butterfly scheme. The service

was audited yearly by the Dementia Care Matters who had trained the home on the Butterfly project. The last audit had been positive.

Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff told us, "I understand whistleblowing. If I have a concern I would go to the nurse and if nothing was done, I would go higher".

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people who used the service were documented, investigated and actions were followed through to reduce the chance of further incidents occurring. For example, one person who was mobile and independent fell. The registered manager investigated for possible causes and it was concluded the person's night medicines could have caused the person to feel unsteady and fall. The GP reviewed the person's medicines and reduced their doses. The registered manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the registered manager. The registered manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager did not have a clear understanding of their responsibilities in relation to completing mental capacity assessments. Where people were thought to lack capacity, assessments in relation to their capacity had not been completed in line with the principles of MCA. The registered manager relied on capacity assessments carried out by other health professionals. Regulation 11 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risk of choking. People were not always protected from the risk of developing pressure sores. People were not always protected from preventing the risk of infection. Regulation 12 (1)(2)(b)(e)(h)