HC-One Limited

White Gables

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection on 4 June 2018.

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

White Gables is located on the edge of a village on the outskirts of Lincoln. It accommodates up to 55 people many of whom are living with dementia requiring high levels of care and nursing. The accommodation is provided on one floor and the building is separated into three separate units called Cedar, Castle and Cathedral. Cedar provides mainly residential care whilst Castle and Cathedral provides for people requiring nursing care. On the day of the inspection there were 42 people living at the home.

At our last inspection in December 2015 we rated the service good. At this inspection, we rated the service as requires improvement. Safe, caring, and well led remained good; however, effective and responsive required improvement. This is the first time the service has been rated Requires Improvement.

There was a registered manager in place. 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.

Systems and processes were in place to ensure people were protected from abuse and people told us they felt safe at the home. Risk assessments were completed to identify risks to people's health and safety but care plans did not always reflect the actions required and we found an example of a delay in obtaining a piece of equipment required to improve a person's safety.

There was a good culture of incident reporting and staff were able to speak up about concerns. Infection risks were controlled and managed well and checks of the premises were in place to maintain the safety of the buildings and equipment. People received their medicines as prescribed and arrangements were in place for the ordering and supply of people's medicines.

People were supported to have maximum choice and control of their lives. Although staff supported people in the least restrictive way, they did not always have a full understanding of the Mental Capacity Act (2005) and specific best interest decision making was not always documented.

When people required support and encouragement with their eating and drinking, we had some concerns as to whether they were receiving sufficient fluids and whether sufficient steps were taken to maximise their nutritional intake. Improvements could be made to the care of people's mouths particularly when they were not able to maintain a good oral intake.

People were supported to access health care and staff sought the advice of a specialist healthcare professionals were necessary. They worked well with other services and acted on the advice provided.

Staff were friendly, encouraging and caring in their approach. People and their relatives praised the attitude of staff and their kindness. They protected people's privacy and dignity and respected their views and choices.

People and their relatives were involved in the development of their care plans. However, some care plans did not contain some key information and the amount of information about their life history and previous interests was sometimes limited.

People's views were listened to and acted upon and complaints were dealt with responsively and effectively.

The home was well-led by a registered manager. People using the service, their relatives and staff praised the registered manager and the support they provided. People and staff were encouraged to contribute to the development of the service. Effective auditing processes were in place to monitor the quality of the service. The registered manager carried out their role in line with their registration with the CQC.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains safe.

Risks to people's health and safety were assessed; however care plans did not always provide sufficient information about the actions to be taken to reduce these risks.

Information and training for staff on how to support people with distressed behaviour was not consistently provided

Overall medicines were managed safely and in line with requirements. People received their medicines as prescribed and staff kept accurate records of medicines administration.

Effective safeguarding systems, policies and procedures were in place and safeguarding concerns were reported and managed appropriately.

People were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments and best interest decisions were not always completed or the decision to which they referred was not clear. However, staff supported people in the least restrictive way.

Daily care records did not always provide evidence that planned care was provided in line with the requirements identified in people's care records. We also had concerns as to whether people were supported to drink sufficiently to meet their needs. The quality of the food could be improved.

People were supported to access health care to meet their needs.

Is the service caring?

Good

The service remains caring.

People were treated with dignity, respect and kindness during all interactions with staff. Their relationships with staff were positive and they sought and gained reassurance from staff.

People, their relatives and an external professional praised staff for their care kindness and friendly approach.

People were encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain detailed and up to date information on their care and information about their previous life history and interests were limited.

Improvements were required to the oral care people received particularly when they were unable to maintain a good oral intake.

People and their relatives were involved in the development of their care plans.

Complaints were dealt with consistently and appropriately. People and their relatives felt confident that any concerns raised would be dealt with immediately.

Is the service well-led?

Good

The service remains well led

The registered manager was experienced, responsive and committed to the development and improvement of services. Staff respected the manager and said they were supportive and fair.

Audits were in place to monitor the quality of care and services provided and action plans were developed to address issues.

The views of staff, people using the service and their relatives were listened to and they were encouraged to identify new ideas and new ways of working.

White Gables

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 4 June 2018 and was unannounced The inspection team consisted of two inspectors and an assistant inspector.

Before the inspection we reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the home including notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. Healthwatch is the local consumer champion for people using adult social care services.

During the inspection we spoke with seven people using the service and six relatives. We spoke with the registered manager, five care staff, a cook, two housekeepers and a maintenance person.
We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not people were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included looking at all or part of five people's care records and associated documents. We reviewed records of meetings, recruitment checks carried out for four staff, staff rotas, staff training records and maintenance and safety logs. We also reviewed the quality assurance audits the management team had completed.

Good

Is the service safe?

Our findings

Risks to people's health and safety were assessed and reviewed. For example, tools were used to assess people's risk of developing pressure ulcers, risk of choking, risk of inadequate nutrition and falls risk. Additional risk assessments were completed when other risks were identified, such as when a person was unable to use a call bell to seek assistance, or when there was a risk of a person falling out of bed. However, risk assessment and care plan documentation did not always provide full information on steps staff should take to reduce these risks. We discussed this with the manager and they were taking steps to improve this? Staff told us people at risk of falls were discussed at 'flash' meetings so that staff were aware of the actions required. Staff told us they had ordered a sensor mat to alert staff when the person tried to walk without assistance, as they were not always aware of their limitations. However, this was not available promptly and increased the risk of staff not being made aware of the person's movements. In the meantime staff told us they were monitoring the person more closely.

People told us they felt safe at the home and relatives confirmed their family member was safe. For example, one relative said, "Yes definitely." They went on to say their family member had moved from another care home where they had concerns and said the care they were receiving currently was vastly improved.

Staff were aware of the signs of abuse and what to look for, such as changes in people's behaviour that might indicate they were being abused. They told us they would report any concerns to the registered manager or the deputy manager and they were aware of how to escalate issues to the provider's management team if necessary. Some staff were also aware of the role of the local authority and that they could refer to them or the CQC if necessary. The registered manager was aware of their responsibility to make safeguarding referrals and records indicated that referrals were made as required.

Some people living with dementia showed distressed behaviours including physical and verbal aggression at times. We found some variability in the amount of information for staff in people's care plans about the best way to respond to this and things which were helpful in calming the individual person and gaining their cooperation. Staff told us they did not use restraint and if possible they would give the person some space and wait until they were calmer.

Staff said they were able to raise concerns and issues which impacted on people's safety. They said that when incidents and accidents occurred they completed an incident form and senior staff entered the information onto an electronic incident reporting system. Records of incidents reported showed there was a good culture of reporting and the provider monitored incidents on a monthly basis to review any patterns or trends.

People and their relatives said they felt there were normally enough staff on duty to meet people's needs. The provider used a dependency score and staffing tool to determine the number of staff required to provide the care and support people required. The registered manager told us they had recently been successful in recruiting additional staff and currently they did not have any vacancies. They said that increased staff turnover in the previous twelve months meant that they currently had a significant number of

less experienced staff. As a result they were taking additional care to ensure the rosters were balanced in relation to skill mix. A member of staff said that staffing levels had improved. They said, "The new people starting are good - much more stable, at the end of last year we had a lot of agency staff." Staff said they felt there were normally enough staff on duty, although some said there were times when they would benefit from additional staff to monitor people in the lounge areas or in the evenings when some people living with dementia became more distressed and anxious. We spoke with the registered manager about this and they said they were reviewing staffing in the twilight period as there were currently a number of people who had additional support needs at this time.

Staff were recruited using safe recruitment practices. Staff files we reviewed contained evidence of systematic processes to check their suitability for their role and that the required pre-employment checks were completed prior to the applicant starting work.

Systems and processes were in place for the regular ordering and supply of people's medicines. Medicines were stored securely in line with legislation and checks of controlled drugs were completed twice daily at staff shift changes. Controlled drugs are closely regulated as they are susceptible to being misused and can cause harm. To ensure they are managed and used safely, legal frameworks for governing their use have been established. We observed the administration of medicines and saw staff checked the medicines administration record (MAR) and stayed with people until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of their allergies and their preferences for taking their medicines. When medicines were hand written on the MAR they were signed by two people to ensure accuracy of transcription. When people were prescribed medicines in the form of skin patches there was a record of the site of application of the patch to ensure they were removed and the site of application was rotated. Protocols were in place to provide additional information for staff to enable the safe and consistent administration of medicines which were prescribed to be given only when required. When one person was being given their medicines covertly (without their consent) an assessment was completed and the agreement of the person's GP and the local pharmacist were obtained. However, we saw another person occasionally needed to be given their medicines covertly, but there was no record of the assessment and agreement of the person's GP to this. We alerted the registered manager to this and they immediately arranged for the GP to provide written authorisation.

Most liquid medicines and topical creams were labelled with the date of opening in line with good practice but we noted one person had several bottles of the same lotion and cream which had all been opened and stored in their room. Staff immediately took action to remove the surplus creams and lotions when it was flagged with them. Records of application of creams were not always consistently recorded; therefore we could not be sure they were always applied as prescribed. This was an area the registered manager said they were addressing.

The provider had a medicines policy in place to ensure the safe management and administration of medicines. Staff administering medicines received training and their competency was assessed annually. We saw records which indicated this was up to date. Staff completed monthly medicines audits and an external audit of medicines was completed in April 2018. This did not identify any major concerns and minor issues identified had mostly been addressed.

People were protected from risks associated with the premises and the improper use and maintenance of equipment. The required safety checks were completed and external assessments were in place as necessary in relation to fire safety, gas and electrical safety and water safety including legionella. Some windows were beginning to lose putty and there was a risk of the glass becoming loose. The manager was already aware of this and the estates department had surveyed for replacement of all windows with UPVC.

One of the fire exit ramps had some tree debris which may hamper exit by a wheelchair. We alerted the manager to this and they agreed to rectify this immediately.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. Records showed that DoLS applications were submitted to the local authority when required and monitored by the registered manager to ensure they were reviewed as necessary. None of the DoLS authorisations had related conditions.

However, we found that mental capacity assessments were not always undertaken when people lacked capacity to make specific decisions for themselves. In addition, when they had been completed, the documentation did not provide information on the specific decision made, or any other options considered. For example, there was no indication in one person's capacity assessment or best interest documentation as to what decision was being considered, whilst another person's care record had a best interest decision which was not specific. We spoke with staff about the Mental Capacity Act and when they might need to undertake a mental capacity assessment. We found knowledge was very variable and some staff responsible for initiating or reviewing care plans did not have a full grasp of the requirements. However, staff were able to describe why the restrictions in place were necessary and supported people in the least restrictive way. Most staff had completed MCA and DoLS training. The registered manager agreed to review people's care records in relation to mental capacity assessments and to ensure staff were provided with training to enable them to fulfil the requirements in the future. Following the inspection they confirmed this was being progressed.

From viewing people's care records we found people's needs and choices had been assessed and care, treatment and support was planned in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. When people had pressure ulcers or wounds, care plans were in place for the care of the wound and staff assessed wound healing regularly and systematically. However, we could not be sure care was always delivered in line with good practice and the person's care plans. For example, a person was unable to move and re-position themselves and was at risk of developing pressure ulcers. Their care plan stated they should be re-positioned every four hours; however there was one gap of five hours and another over six hours between re-positioning in one 24 hours period. Another person was cared for in bed and their care record also stated they should be re-positioned every four hours, and we found some gaps of over five hours. We also found entries on a re-positioning chart and a percutaneous endoscopic gastrostomy (PEG) nutrition chart which indicated charts were not always filled in at the time care was delivered, as an earlier entry was made after a later entry. PEG nutrition is provided when a person is given specially

formulated liquid food through a flexible feeding tube which is placed through the abdomen and into the stomach. PEG nutrition charts were difficult to interpret and were not consistently completed. However, after careful examination we concluded that people receiving nutrition this way were being provided with the amount prescribed by the dietician.

People were provided with a nutritious, balanced diet and they were offered choices at each meal time. However, we received mixed feedback from people about the quality of the food and we saw an occasion when a person was unable to eat the meat as they said it was too tough. From the subsequent conversation, there was similar feedback from others and it appeared it was not an unusual occurrence. Staff offered the person the pasta alternative. One person said, "All lunches taste the same apart from fish and chips on a Friday which I love." We observed there was a lot of food waste left on plates at lunchtime and the food did not look appetising. Catering staff were substituting recipe ingredients as they told us they were unable to obtain some ingredients due to supply issues. A person's relatives said they felt there should be reduced sugar desserts for people with diabetes and they were a little concerned that everyone was given the same desserts. When we raised this with the management team they told us the desserts were sweetened with sweeteners and were suitable for people with diabetes. Although diet notification forms were used to inform catering and care staff of people's dietary needs, there was little information on their particular food preferences. When we asked the catering staff about the action they took when people were losing weight they told us they fortified their food; however, they did not tell us they made any effort to discover their favourite foods and provide this to tempt them to eat.

We observed the lunchtime dining experience and found that generally people were supported to eat independently and provided with encouragement and prompting. We also saw staff provided one to one assistance for some people, sitting with them and enabling them to eat at their own pace. However, we saw one member of staff standing next to the person when they were providing assistance rather than sitting with them to provide support. This did not provide a positive experience for the person. Following the inspection the registered manager contacted us to inform us they had provided additional on the floor training for care staff about the importance of being seated when providing assistance at meal times.

When people were at risk of not eating and drinking sufficiently, staff completed food and fluid charts to monitor the amount they ate. However, we found they were not completed consistently and this gave us some concern as to whether the person was being encouraged and supported to drink sufficient quantities of fluids. For example, two people's fluid charts indicated they had each drunk no more than 400mls in one 24 hour period. Another person was recorded as being reluctant to eat and drink and their fluid chart indicated they were offered fluids at mealtimes and during the mid-morning and mid-afternoon drinks rounds, however, we did not see evidence of them being offered additional fluids in between these times. The relatives of two people we talked with also expressed doubts about the amount of drinks people were given, particularly as they were prone to urinary tract infections. A person's care plan stated they required their drinks to be thickened to "syrup thickness" as they were at risk of choking. A relative told us, and we observed that their drinks were much thicker than this, which made them difficult to drink. The relative said the thickness was variable and depended on whether the scoop used to measure the thickener was packed or rounded. On another day the food chart was not completed at all. Together these observations gave us concern as to whether people were always receiving adequate amounts to drink. Food charts were also inconsistently completed. A person's food chart indicated they had two sandwiches and a piece of cake at 8.20pm on one day, but there were no other entries that day. The registered manager said they felt this was a recording issue rather than an absence of food and they would look into it.

People were supported with their day to day healthcare. We saw people were supported to access their GP when they were unwell and we saw evidence of the involvement of other professionals such as chiropodists,

opticians and dentists. A visiting professional said staff referred people appropriately and followed their advice when providing support to people. Relatives told us staff contacted the GP if they had any concerns about their family member's health and contacted them to let them know. They told us staff communicated well with them and kept them informed of any changes to their family member's care plan.

Relatives had confidence in the staff providing care and their skills and knowledge.
The registered manager provided a copy of the home's training records which showed that most staff were up to date with their mandatory training but we noted that safeguarding training and moving and handling training showed lower levels of compliance that other topics and the percentage of staff who were up to date with other training topics was below the provider's target of 85%. Staff told us they were reminded to undertake their mandatory training and the registered manager spoke with them if they were late in completing it. We saw the requirement to improve compliance with mandatory training was on the home's improvement plan.

Some of the staff who mainly worked in the residential unit told us they had not completed training in managing challenging behaviours and felt they would benefit from such training. The registered manager told us they would look into this.

The premises were reasonably accessible for people, however we noted and staff told us they experienced some difficulties when moving people in their adapted chairs as they only just fitted through the door ways. Pictorial signs indicated the doors to bathrooms in most areas but there was little signage to help people find their way and the corridors had few identifying features. We noted some interactive pictures in some areas and a board with keys and switches and another with fabrics to encourage touch. In some areas of the home the flooring was poorly maintained and we were told it was scheduled for replacement, but the timescale was unclear. There were some odours from external drains in some parts of the service; the registered manager told us they were being dealt with. Two relatives commented on the lack of space in people's bedrooms and the lack of chairs for visitors. We observed that when people were receiving PEG nutrition, the boxes of supplies were stored in people's bedrooms resulting in them appearing cluttered and further reducing the space. The registered manager said they did not have alternative storage areas for these items and there were very limited storage facilities in the building. However they said they showed us some re-furbished rooms with more space and en-suite facilities. They said the long term plan was to increase the provision of en-suite facilities.

Good

Is the service caring?

Our findings

People and their relatives were extremely positive about the care and kindness of staff towards the people using the service and relatives felt welcomed into the home. One person said, "All the staff are lovely and they all want to help," whilst another person spoke about the friendliness of staff and their kindness towards them. Two sets of relatives commented on how well their family member had settled in the home and that they seemed very happy. They attributed this to the attitude of staff and commented their friendliness and the way they interacted with everyone.

We received positive feedback from an external professional who was complimentary about the staff being kind and caring and they told us staff knew people well.

We observed that staff engaged with people positively and respectfully showing sensitivity towards them. Staff showed understanding and empathy for people and supported them in a caring manner. We observed several occasions when people called out in distress and staff responded quickly in a calm and reassuring manner, showing understanding towards the person and a gentle kindness, reaching out to them in a way that showed they cared. They stayed with the person for a while to ensure the person was calm and on one occasion we saw them telling the person where they were going and when they would be coming back. We saw people responded well to staff and they relaxed quickly in their presence.

We saw people had strong relationships with staff and they approached staff to obtain reassurance when needed. We saw a person using the service sat at the door to their room and engaged with staff as they passed. We saw the maintenance man chatting with the person and they clearly appreciated this and responded with a smile and obvious pleasure.

Two sets of relatives told us their family member was clearly well cared for and told us how important it was to their family member to be clean and well presented. They told us their family member had always taken pride in their appearance and it was important to them and their dignity and sense of well-being.

We observed staff respecting people's privacy by knocking on their bedroom door before entering and taking them away from others when they needed to attend to them. Staff told us they always protected people's modesty during personal care by covering them as much as possible and encouraging them to complete parts of their personal care themselves if they were able.

We visited a person who was nearing the end of their life and receiving end of life care. Staff spoke quietly and gently to the person, making sure they were as comfortable as possible. When we asked a member of staff if the person was experiencing any pain, they told us that they appeared comfortable at the moment, but they could tell by the person's expressions if they were in pain and when this occurred they told the nurse who was able to administer pain relief. We had a brief conversation with a representative of the local church who visited the person. They told us they felt the person looked "at peace" in the home when they had shown signs of distress prior to their admission.

Relatives told us they were involved in decisions about their family member's care and staff communicated well with them. We saw some evidence of involvement of relatives and people in the review of their care plans.

People's care plans contained information about people's level of independence including what daily living tasks they were able to do for themselves and what tasks they required support with. People told us they were supported to maintain their independence and a relative told us of how their family member was being supported to start to get out of bed following an admission to hospital when they had been cared for in bed. The registered manager told us of a person with mental health issues who had not initially settled well into the unit and who was very anxious. However, they had suggested to the person and their relatives that they might prefer to be in a different quieter area of the home with direct access to the garden and en-suite facilities. Since their move they had become more independent and the manager showed us a card they had received that day from the person's relatives thanking staff for making the move possible and saying how it had benefited the person.

Information was available in the main reception area about an independent advocacy service which was available for people if required. We spoke with the manager about this and they told us they had used the service previously but no one was currently supported by an advocate.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed and care plans were developed to meet their individual needs. They contained information about people's individual preferences and wishes in relation to their care and were evaluated monthly. Although staff knew people well, some of the care plans lacked detail in places. For example, a person's mobility care plan did not refer to their falls risk or that a sensor mat had been ordered and there was no information for staff about how to respond when a person was reluctant to allow staff to support them in their personal care. Pressure ulcer prevention care plans did not always state how frequently staff should re-position the person when they were unable to adjust their position themselves. There was no care plan for the care and management of their PEG nutrition tube. A person was at high risk of choking and their nutritional care plan did not refer to this, although we saw staff were providing full assistance to the person with their eating and drinking. Another person had fallen on a number of occasions in the recent three weeks. Their mobility care plan didn't refer to this. We saw some measures were in place to monitor the person and provide assistance where necessary. Following the inspection the registered manager confirmed they were reviewing care plans to ensure they incorporated the actions in relation to risk assessments.

There was limited life history information available in care records. The registered manager had completed an audit of most care plans over the previous month and staff were in the process of updating them and addressing shortfalls identified in the audit. The registered manager and area manager told us they would add actions from this inspection to the improvement plan.

Care records contained an oral care assessment for each person. However, two relatives told us they had concerns about the frequency and effectiveness of oral care as they relative's mouth frequently appeared dry and crusted. The registered manager told us this was an area they had identified required attention and therefore all staff supervision meetings the previous month had included a discussion about oral care. They were considering other action to be taken as it was identified on the home's improvement plan.

The registered manager told us they were aware of their responsibilities in relation to the accessible information standard. This standard expects provider's to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. Communication care plans were developed for people and they identified any sensory impairment and whether they wore glasses or a hearing aid. The registered manager told us they provided MP3 players with stories and music for people with sight loss and had a selection of large print books. They said they were arranging for a person to have an adapted call bell with a large call button to enable them to call for assistance as they were unable to use the standard one. They said they had previously cared for a person who was registered blind and they had a braille watch and braille radio.

A range of activities were available for people and we saw evidence of visits from external entertainers and were told of the annual dog show and fete held by the home. There were occasional visits to external venues such as the nearby wildlife park. On the day of the inspection a person was planting flowers in the garden with the activities coordinator and others were watching. We heard about the 'knit and natter' group and

music therapy, as well as craft activities. However, we received some feedback from relatives and staff about a lack of stimulation and activities for people who were cared for in bed and those with advanced dementia. A person made the comment, "There is lots to do for [the more able], but they could do more for others." Another person said, "There could be more activities, especially for those less able." Our observations during the inspection supported these comments. However, the activities coordinator said, "There's no one in this home that we can't do some [activity] with."

The provider kept a register of all complaints and compliments received. We reviewed these and saw there was a large volume of compliments about the care and support staff provided. We saw complaints were responded to appropriately and in a timely manner. The registered manager investigated complaints thoroughly and actions were identified to rectify the concerns identified.

An end of life care plan was in place for a person who was reaching the end of their life. The care plan was clear about the level of action to be taken as the person's health deteriorated, what was important to them and how staff could keep the person comfortable. Medicines were available to treat the person's possible symptoms and staff were clear about when these might be needed. Their care plan indicated they wanted to stay at the home until they passed away. Contact information for their family and the local clergy for their faith was available. Staff had not completed recent training in end of life care but they demonstrated knowledge of the importance of a holistic and individualised approach and the support available.

Good

Is the service well-led?

Our findings

There was a registered manager in post. The registered manager had very recently returned after a period of extended leave and in their absence, the home had been supported on an interim basis by a number of the provider's management team. This had resulted in some fragmentation of leadership and some staff turnover. However, new staff had been recruited and staff were very positive about the return of the registered manager and their leadership and management skills. A member of staff said, "There's a good team now –there's better staff here. We can solve a lot of problems on our own and the manager is always there if we need them." Another member of staff said they was always someone to call or refer to if they needed to. Staff were clear about their reporting lines and their responsibilities.

Relatives were spoke with also had confidence in the management team and told us any concerns or issues were immediately dealt with. The registered manager was available for them and they could ask to speak to someone if they needed to.

The registered manager was experienced and had a good understanding of their responsibilities. They showed a commitment to improving and developing the service. They were aware of their duty to make the required notifications to the CQC. The CQC ratings from the last inspection were displayed on the provider's website and in the front entrance of the home. We also viewed the report from the local commissioners of the care at the service and saw the results were positive and they found the service was meeting the outcomes required for its residents.

Staff said they were encouraged to contribute new ideas and suggest new ways of working. We saw information displayed about a 'blue marshmallow scheme' to encourage innovation and creativity of thought amongst the staff team and sharing innovation and ideas from other services. The home had trialled the use of cognitive stimulation therapy supported by an external facilitator and aimed at helping people living with dementia to engage more effectively and improve their sense of well-being. They were considering continuing this.

The management team completed a range of monthly and quarterly audits to monitor the quality of the service and the care provided. These included audits of specific aspects of care such as medicines, falls and care records and wider audits such as audits of infection control, catering, and health and safety. The audits were effective in identifying most of the issues we identified during the inspection and the registered manager was addressing them. The home had an integrated improvement plan which included actions to improve against all of these areas. Representatives of the provider also visited the home monthly and carried out a review of the care provided. They provided a visit report for the registered manager which included actions required and a review of actions. Following our inspection the registered manager provided us with a comprehensive list of the actions they had taken to address the issues we identified during the inspection and told us an action plan had been developed.

The registered manager held regular meetings for relatives and people using the service. The most recent meeting was held in April 2018 and the minutes of the meeting indicated that actions from the previous

meeting were discussed, along with updates on staffing and recruitment, planned activities and news since the previous meeting.

A relative's feedback survey had been completed in June 2017. This indicated overall satisfaction with the care provided with the most positive feedback relating to kindness of staff, staffing levels and management. The lowest scoring areas were food and facilities although 83% and 87% of relatives rated these areas as good or excellent. The registered manager accepted there had been limited follow up action in response to the survey in their absence.

Monthly team meeting dates were planned for the year and staff told us meetings occurred regularly for staff and there were additional monthly meetings for nursing staff. A staff survey was completed at the end of 2017 and a number or actions were identified from this with timescales for completion. The action plan we reviewed indicated that most of the actions were in progress or had been completed. One of the actions we saw from the survey which we witnessed during the inspection was a daily flash meeting to improve communication.