St. Mary's Care Limited

St Mary's Care Home

Inspection report

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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

People living in St Mary's Care Home receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection

The care home can accommodate up to 82 people across five separate units, each of which have separate adapted facilities. The two units known as Rose and Lavender wings specialise in providing care to older people living with advanced dementia. The three other units, known as Orchid, Jasmine and Daffodil wings specialise in supporting older people with personal care needs. At the time of our inspection 78 people resided at the care home.

At the last comprehensive CQC inspection of this care home in September 2015 we rated the service 'Good' overall and for each of the five key questions. We carried out a focused inspection in June 2016 in response to concerns we received about there being a lack of competent staff working in the care home to meet people needs. We found there were enough suitably trained staff on duty at the time of that inspection. At this inspection we have changed the care home's overall rating and for the three key questions is the service Safe, Effective and Well-led? to 'Requires Improvement'.

We rated the service 'Requires Improvement' because the provider did not operate effective staff recruitment and quality monitoring systems. We found recorded evidence was not always available in staff's files to show the provider had obtained two professional or character references for all new staff. This meant the provider had not done enough to satisfy themselves of the suitability of staff working at the care home. Furthermore, although we saw systems had been established to monitor and review the quality and safety of the service people living at the care home received, the provider had failed to pick up most of the issues we identified during this inspection, specifically in relation to staff recruitment and the support they received from management.

These failings represent two breaches of the Health and Social Care (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We have also made a recommendation about the home's environment and design not being as dementia 'friendly' as it could be. Although we saw there were some signs displayed throughout the care home to help people identify toilets and bathrooms, most bedroom doors lacked any visual cues in order to make the room more recognisable to people. We also saw communal areas had all been painted in identical neutral colours. This lack of visual stimulation might lead to people living with dementia becoming disorientated.

The service had a newly registered manager who had been in post since August 2017. This is the third registered manager the service has had in the last seven years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the

Health and Social Care Act and associated Regulations about how the service is run.

People and their relatives told us they were happy with the standard of care provided at the home. We saw staff looked after people in a way which was kind and caring. Staff had built up caring and friendly relationships with people and their relatives. Our discussions with people living in the home, their relatives and community health care professionals supported this.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. The provider assessed and managed risks to people's safety in a way that considered their individual needs. There were enough staff to keep people safe. The premises and equipment were safe for people to use because managers and staff routinely carried out health and safety checks. Medicines were managed safely and people received them as prescribed.

Staff received appropriate training to ensure they had the knowledge and skills needed to perform their roles effectively. People were supported to eat and drink enough to meet their dietary needs and preferences. They also received the support they needed to stay healthy and to access healthcare services.

Staff were caring, treated people with dignity and respect and ensured their privacy was maintained, particularly when being supported with their personal care needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were nearing the end of their life, they received compassionate and supportive care.

People received personalised support that was responsive to their individual needs. Each person had an up to date and personalised care plan, which set out how their care and support needs should be met by staff. This meant people were supported by staff that knew them well and understood their needs, preferences and interests. Staff encouraged people to actively participate in meaningful leisure activities that reflected their social interests and to maintain relationships with people that mattered to them.

People felt comfortable raising any issues they might have about the home with managers and staff. The service had arrangements in place to deal with people's concerns and complaints appropriately. The provider also routinely gathered feedback from people living in the home, their relatives and staff.

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

Some aspects of the service were not safe. This was because the provider did not always consistently operate safe recruitment procedures. This meant the provider had not done enough to satisfy themselves about the suitability of new and existing staff.

There were enough staff suitably deployed in the home to keep people safe.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse.

The provider had assessments and management plans in place to minimise possible risks to people, this included infection control and food handling measures.

The premises and equipment were safe for people to use because staff routinely carried out health and safety checks.

Medicines were managed safely and people received them as prescribed.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The service's arrangements for support, supervising and appraising staffs work performance were not effectively operated. This meant staff might not have the right levels of support, knowledge and skills to carry out their duties effectively.

The registered manager and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access healthcare services.

Is the service caring?

Good

The service was caring. People said staff were kind, caring and

respectful.

Staff were thoughtful and considerate when delivering care to people. They ensured people's right to privacy and to be treated with dignity was maintained, particularly when receiving personal care.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Is the service responsive?

Good

The service was responsive. People were involved in discussions and decisions about their care and support needs.

People had an up to date, personalised care plan, which set out how staff should meet their care and support needs. This meant people were supported by staff that knew them well and understood their individual needs, preferences and interests.

Staff encouraged people to actively participate in leisure activities, pursue their social interests and to maintain relationships with people that mattered to them.

People knew how to make a complaint if they were dissatisfied with the service they received. The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

When people were nearing the end of their life, they received compassionate and supportive care from the service.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Although systems were in place to monitor and review the quality of service delivery; these governance systems were not always effectively operated because they had failed to identify a number of concerns we had found during our inspection.

The provider routinely gathered feedback from people using the service, their relatives and care workers. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

St Mary's Care 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 was an unannounced comprehensive inspection which took place on 13 and 18 December 2017. The inspection was carried out by an inspector 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.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us annually to give some key information about the service, what the service does well and improvements they plan to make.

During this two-day inspection we spoke with ten people who lived at the care home, five visiting relatives, two clergymen and four community health and social care professionals including a GP, tissue viability nurse, a chiropodist and local authority care manager. We also talked with various people who worked at the care home including, the registered manager, two unit managers, two registered nurses, eight health care assistance, two activities coordinators, the head cook and two business support staff.

We also observed the way staff interacted with people living in the home and performed their duties. During lunch on both days of the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included ten people's care plans, ten staff files and a range of other documents that related to the overall management of the service which included quality assurance audits, medicines administration sheets, complaints records, and accidents and incident reports.

After our inspection we received email feedback from two community nurses working for local NHS

Commissioning Care Groups (CCG).

Requires Improvement

Is the service safe?

Our findings

The provider's recruitment processes were not sufficiently robust to mitigate the risk of people being cared for by staff who might not be 'fit' and 'proper'. Records indicated most pre-employment checks had been undertaken by the provider in relation to new staff's identity, criminal record and eligibility to work in the UK. However, five out of eight staff files we looked out for staff employed in the last 12 months did not include two professional and/or character references. This meant the provider had not done enough to satisfy themselves about the suitability and fitness of new staff.

This represents a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook a focused inspection of this service on 9 June 2016 to follow up on concerns we had received about there not always being enough staff on duty to meet people needs. At that inspection we found the care home was sufficiently staffed. During this inspection we saw the service continued to ensure there were sufficient numbers of nursing and care staff on duty to meet people's needs. People told us there were always enough staff working in the home. One person said, "The staff are very busy, but usually they [staff] only take a few minutes to come if I call them", while a relative told us, "I think staffing levels have been increased recently, so there's always enough staff about now." A community health care professional also remarked, "I think increases in the number of staff you now see working on the units is the single biggest improvement the home has made in the past year." Throughout our inspection we saw care staff were always visible in communal areas, which meant people could alert staff whenever they needed them. We also saw numerous examples of nurses and care staff responding quickly when people used their call bells or verbally requested assistance to stand or have a drink.

Nonetheless people said they continued to feel safe living at St Mary's Care Home. One person told us, "If I felt unsafe I would go and live with my [family member]", while another person remarked, "There is nothing to make me feel unsafe here. I would just get and up and leave if I didn't feel safe". Relatives also told us they felt their family members were safe at the home. One relative commented, "I feel my [family member] is safe because of the carers that work here, who are all fantastic."

The provider had robust systems in place to identify, report and act on signs or allegations of abuse or neglect. A community social care professional told us, "In my experience the service deals with safeguarding incidents when they arise openly and professionally." Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. One member of staff told us, "If I ever saw anyone being abused here I would make sure the people involved were safe first and then tell the nurse in charge what I had seen."

We looked at documentation where there had been safeguarding concerns raised in respect of people living at the home in the last 12 months and were assured the provider had taken appropriate action to mitigate the risks associated with these incidents. We saw the registered manager had liaised with the relevant local

authority about the concerns raised so they were aware of the outcome of the investigation and any learning to ensure people remained safe and to prevent similar incidents reoccurring.

Care plans clearly identified people's behaviours that might be perceived as challenging, but contained no risk management plans to help staff prevent or deescalate such an incident. Staff said they had not received any training in de-escalation techniques where people may display behaviours that might challenge the service. Several staff also told us they did not always feel confident dealing with incidents of challenging behaviour and would benefit from attending a positive behavioural support training course. We discussed this matter with the registered manager who agreed to seek advice from the relevant community health and social care professionals, review and update care plans for people whose behaviour might challenge and ensure staff received positive behavioural support training. Progress made by the service to achieve this stated aim will be assessed at their next inspection.

Measures were in place to reduce identified risks to people's health, safety and welfare. Managers assessed and reviewed risks to people due to their specific health care needs. Risk management plans were in place for staff to follow to reduce these identified risks and keep people safe whilst allowing them as much freedom as possible. This included, for example, eating and drinking, mobility and safe transfer using a hoist, and skin care. Our observations and discussions showed staff understood the risks people might face and took appropriate action to minimise them. For example, we saw staff followed individual guidance when supporting people to transfer safely from an armchair to a wheelchair using a mobile hoist.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency plans to help staff deal with such events quickly. For example, a personal emergency evacuation plan (PEEP) had been developed for each person who used the service, which provided guidance for staff if people needed to be evacuated from the premises in the event of a fire. Staff demonstrated a good understanding of their fire safety roles and responsibilities and told us they received on-going fire safety training. The London Fire and Emergency Planning Authority (LFEPA) carried out an inspection of the care home's fire safety arrangements in March 2017 which they found to be satisfactory.

People were protected by the prevention and control of infection. People told us the home was always clean. One person said, "I think the home is kept very clean." During tours of the premises throughout our inspection we saw the home looked clean and remained free from odours. We also saw staff always wore disposable gloves and aprons when providing personal care to people. The provider had an up to date infection control policy and procedures. Records showed staff had completed up to date infection prevention and control training.

Appropriate systems were in place to minimise any risks to people's health during food preparation. For example the use of colour coded chopping boards and the daily checking of fridge and freezer temperatures. This showed that there were measures in place to help protect people from the risk of infection due to an unhygienic environment. Following a recent inspection the Food Standards Agency had rated the care home's food hygiene practices as being 'very good'.

There were robust systems in place to ensure medicines were managed safely. People's care plans contained detailed information regarding their medicines and how they needed and preferred these to be administered. We looked at medicines administration records (MARs) which should be completed by staff each time medicines were given. There were no gaps or omissions which indicated people received their medicines as prescribed. Our checks of stocks and balances of people's medicines confirmed these had been given as indicated on people's MAR sheets. Staff received training in the safe management of

medicines and their competency to handle medicines safely was routinely assessed.

Requires Improvement

Is the service effective?

Our findings

The provider's systems for ensuring staff received all the support they needed from their line managers and had their working practices routinely appraised were not operated consistently. Staff records indicated most nurses and care staff who had worked at the home for over two years had not attended bi-monthly supervision meetings with their line manager or had their overall work performance appraised annually. This contradicted the provider's staff supervision and appraisal policy which stated staff must attend at least one supervision meeting with their line manager every two months and have their work performance appraised yearly. In addition, whilst staff told us they felt supported by their line managers, several mentioned formal supervision meetings they had with them could be irregular. One member of staff said, "I get on well with the managers here, but I can't remember the last time I had an appraisal." Another member of staff remarked, "I had a supervision meeting with my manager the other month, but there was quite a gap between the last one." This meant staff were not consistently supported by managers to maintain their professional skills or knowledge of best practice.

We discussed this issue with the registered manager who acknowledged staff would benefit from having more frequent opportunities to meet their line managers to review their working practices and training needs. The registered manager told us they planned to review the provider's staff supervision policy and ensure all staff attended individual meetings with their line manager at least once a quarter, which would include an annual appraisal of their overall work performance. Progress made by the provider to achieve this stated aim will be assessed at the care home's next inspection.

This issue notwithstanding people and their relatives told us staff were good at their jobs. One person said, "I believe the staff do get in-service training. They [staff] all seem to know what they're doing", while a relative told us, "The training the nurses and care staff get must pretty good because they know how to look after my [family member]." Staff received an induction when they first employed by the provider and mandatory training which was routinely refreshed. The induction included core training and information about staff roles and responsibilities. It also outlined the home's expectations of staff and the support they could expect to receive from managers. Systems were in place to ensure staff stayed up to date with training considered mandatory by the provider. Records indicated staff had recently completed training in dementia awareness, moving and handling, fire safety, food hygiene, equality and diversity, first aid, and prevention and control of infection. Where people had specific needs, staff received specialist training in those areas. For example, staff that supported people with urinary catheters had been trained to perform this aspect of their role. Staff spoke positively about the training they had received and said they had access to all the training they needed to perform their jobs well.

People told us St Mary's Care Home was a comfortable place to live. A relative said, "They've done a good job refurbishing the place lately and I particularly like what they've done in the main dining room." During a tour of the premises were observed the environment had been well-maintained and furnished.

However, we saw signage used in the home to help people orientate and to identify important rooms or areas such as their bedroom, lounges and dining rooms and bathrooms and toilets, varied from unit to unit.

For example, although we saw some people's bedroom doors had photographs of the person who occupied a particular room, many lacked any visual clues to help people identify their room. We also saw communal areas such as dining rooms, hallways and bedroom doors had been painted identical neutral colours. This lack of colour contrast meant a lot of the communal areas looked the same. We discussed this matter with the registered manager who agreed the service's physical environment could be improved to help people living with dementia orientate themselves and find their way around the home more easily. The registered manager told us they planned to put up easier to understand dementia friendly signs and visual clues throughout the home, as well as install memory boxes near people bedroom doors. These boxes can be used to display family photographs and objects familiar to an individual. We recommend that the service seek relevant guidance and research on the design of the environment for people living with dementia.

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 make 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. At the time of our inspection 50 Deprivation of Liberty Safeguards (DoLS) authorisations were in place. We confirmed that the relevant paperwork was in place, the authorisations were up to date and any conditions were being met. A social care professional told us, "The staff here are very good at carrying out mental capacity assessments and always submit DoLS application to us [the local authority] when they feel a person lacks the capacity to make decisions."

The provider reminded staff to explain the care and support they provided and offer choices to people routinely. We saw people living in the home, or their representatives, signed care plans to indicate they agreed to the support provided. Staff told us they asked people for their consent before delivering care or treatment and respected people's decision if they refused support.

People were supported to have enough to eat and drink. People typically described the quality and choice of the food and drink they were offered at the home as "good". Comments included, "The meals are always good quality here", "The food and service is tip-top" and "The food is great. You can choose what you eat at mealtimes." We saw people could choose between having a meat, fish or vegetarian meal for their lunch on both days of our inspection. Care plans included detailed nutritional assessments which informed staff about people's food preferences and the risks associated with them eating and drinking. For example, if people were at risk of choking, or needed a soft or pureed diet. It was clear from information contained in one person's care plan and comments we received from staff they knew how to manage this individuals diabetes through their diet. Staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these individuals continued to eat and drink adequate amounts.

People were supported to maintain good health. Community health care professionals told us they felt staff had improved their practices in the past year and were now much better at meeting their client's health care needs. One health care professional said, "I'm a lot happier with the way the home manages pressure sores these days. Staff are sending us referrals earlier, which helps prevention, and they [staff] are far more diligent when it comes to following my advice and the pressure sore management plans that are in place." People's individual health action plans set out how staff should be meeting people's specific health care needs. Staff ensured people attended regular appointments with their GP or consultant overseeing their specialist health needs and maintained appropriate records of these check-ups. During our inspection we saw GP's, a tissue viability nurse and a chiropodist who all confirmed they regularly visited the care home.

The service had introduced an integrated pathway scheme where people were each given a red bag that contained standardised paperwork, their medicines and personal items, which would accompany them to hospital in the event of them being admitted. The Red bag ensures essential information about a person's health and belongings is in one place making is easily accessible to ambulance and medical staff during a person's stay in hospital.

Good

Is the service caring?

Our findings

People and their relatives told us they were happy living at the care home and were complimentary about the staff who worked there. People typically described staff as "friendly" and "kind". One person said, "Staff are very kind. They [staff] are wonderful", while a relative remarked, "I'm delighted with the way my [family member] is cared for here. The staff are marvellous compared to where my [family member] previously lived." Community health and social care professionals were equally complimentary about the care home and said they had seen the standard of care improve in the last 12 months. Typical comments we received included, "We currently have no concerns regarding the home. At the last visit in August there were significant improvements from the previous visit", "The service has significantly improved in the last year now they have enough competent staff working here" and "No problems with the service. The staff do an excellent job."

We observed positive relationships had been developed between staff and the people living in the home. Staff focused on people and seemed to genuinely enjoy the company of the people living at St Mary's Care Home. People looked at ease in staff's presence. Staff responded positively to people's questions and requests for assistance. Staff also gave people their full attention during conversations and spoke to people in a kind and considerate way. For example, during lunch we saw staff often ask people if they were enjoying their meal or needed a drink.

We saw care plans included a section on communication which contained detailed guidance for staff on how to meet people's specific communication needs. For example, one care plan we looked at made it clear to staff they needed to always speak slowly and clearly when communicating with this individual, and allow them plenty of time to respond to questions.

People's privacy and dignity continued to be respected and maintained. People told us staff treated them with dignity and respect. One person said, "I am always treated with dignity and respect by the staff here." Another person gave us an example of how a member of staff had been "very sweet" when they had provided them with personal care in the privacy of their bedroom in a manner which they said had "not humiliated me". Personal care was attended to in the privacy of people's bedrooms and/or bathrooms, and staff were observed offering support discreetly in order to maintain people's dignity. The service had a named nurse who was a qualified 'Dignity Champion' whose primary role was to ensure staff remained aware of how to respect and treat people with dignity and respect. Staff gave us some good examples of how they respected people's dignity which included, ensuring bedroom and toilet/bathroom doors were kept closed when they were supporting people with their personal care and addressing people by their preferred name. Staff were aware of the importance of ensuring information about people was kept confidential.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. Information about people's spiritual needs was included in their care plan. One person told us, "The best thing about living at St Mary's is the chapel, where I can attend mass twice a week." We spoke with a visiting Catholic priest during our inspection who was preparing to give mass to people living in the home, their

relatives and staff who had gathered in the home's chapel. Staff told us religious leaders who represented various faiths regularly visited the care home either as part of their weekly schedule or at the request of an individual. Staff were aware of people's backgrounds and their cultures. For example, the cook and several members of staff we spoke with knew who only ate Halal meat and who did not eat beef or pork on religious grounds. We also saw the cook routinely prepared culturally specific meals, such as curry, rice and peas, plantain and semolina, for people with Caribbean, central African and Asian heritage who had expressed a wish to sometimes have this style of food on the menu.

The service continued to support people to be as independent as possible. Although most people living in the care home were dependent on the care and support they received from staff with day-to-day activities and tasks, staff still encouraged people to be as independent as they could be. For example, one person told us they liked to go shopping in the local community once a month for their toiletries, which staff supported them to continue doing. Several relatives gave us examples of staff actively encouraging their family members to continue dressing themselves. We saw hand rails and ramps were available throughout the home to enable people to move freely around the units. Care plans reflected this approach and included detailed information about people's dependency levels and more specifically what they could do for themselves and what help they needed with tasks they couldn't undertake independently.

Good

Is the service responsive?

Our findings

People continued to receive personalised care which was responsive to their needs. People said they had been involved in developing their care plan. These plans were written in a person centred way that focused on their individual care needs, abilities and preferences. They also included detailed information about how people preferred care staff to deliver their personal care and who was important to them, such as close family members and friends. For example, people's daily routine set out for staff when people liked to wake up, how they wished to be supported with getting washed and dressed and when and where they would like to eat their meals. This ensured staff knew how to deliver care and support that met people's needs and wishes.

Care plans were routinely reviewed and updated if there had been changes to a person's needs and/or circumstances. Where changes were identified, people's care plans were updated quickly and information about this was shared with staff through shift handovers, each unit's communication book and various meetings. Staff were knowledgeable about the people they were supporting, knew what was important to them and provided support in line with people's needs and expressed wishes. For example, staff were able to explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people were able to do independently. People had a designated keyworker. This was a member of staff assigned to a person to make sure their care needs were met, and their choices about their care were known and respected.

People were given choices about various aspects of their daily lives. People told us staff supported them to make choices every day about the care and support they received. One person said, "Staff always ask me what I would like to eat and drink at mealtimes." A relative told us, "The staff know my [family member] no longer likes to wear clothes that you have to pull over their head, such as jumpers, which the staff respect." Throughout our inspection we heard staff ask people where they wanted to be and what they wanted to eat and drink. Care plans clearly stated people's preferences regarding the gender of the staff that provided their personal care, which visiting relatives confirmed staff always respected.

People had opportunities to participate in meaningful social activities. A relative told us, "My [family member] is at mass right now. The activities coordinators are very good. They have reminiscent activities and often play music here." We saw the activities coordinators on both days of our inspection support people who wished to attend mass in the home's chapel and watch a movie presentation in the home's dedicated cinema room. We also saw an activities coordinator initiate a game of cards with one person and dominoes with another. There was a weekly timetable of activities which included daily exercise classes, quizzes, cinema club, reminiscence sessions, bingo, music and hairdressing. An activities coordinator told us they ensured people who liked to spend time on their own had opportunities to engage socially with staff in their bedroom. They gave us a good example of how they had encouraged a person who was at risks of becoming socially isolated in their bedroom to come out of their room on a daily bases to play dominoes with them.

The service had suitable arrangements in place to respond to people's concerns and complaints. People

and their relatives told us they knew how to make a complaint if they were not happy with the service provided at the home. One person said, "I haven't needed to complain, but I do know how to if I wasn't happy about something", while a relative commented, "I did tell the nurse in charge I was concerned about my [family members] missing clothing, which to be fair to the staff they sorted out pretty quickly once I had mentioned it." People confirmed they had been given a copy of the provider's complaints procedure when they first moved into the care home. Most people we spoke with who had raised a concern about the care home said they had found the complaints process easy to use. They also said they felt they had been listened to and their concerns investigated thoroughly. Records showed when a concern or complaint had been received the registered manager had conducted a full investigation, provided appropriate feedback to the person making the complaint and offered an apology where this was appropriate when people experienced poor quality care from the service.

When people were nearing the end of their life, they received compassionate and supportive care at the home. Care plans contained a section that people could complete if they wanted to record their wishes during illness or death. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care plans. Records showed staff had completed up to date end of life care training. Managers told us they worked closely with various community based palliative care professionals, including those from a local hospice, when people they supported were nearing the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not always operated consistently by the provider. Although the provider had some relatively new quality monitoring systems in place which ensured care plans, medicines management, food hygiene, infection control and the environmental standards were routinely checked; we found these arrangements had failed to pick up a number of issues we identified during our inspection. For example, we found poor record keeping in relation to the maintenance of staff files which meant it was not clear whether or not all the appropriate recruitment checks had been carried out for new staff and existing staff regularly attended supervision and appraisals session with their line managers. In addition, care plans did not always include risk management guidance to help staff prevent or de-escalate behaviours that could be interpreted as challenging.

This represented a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This breach notwithstanding we saw the provider had recently arranged for an independent consultancy company to help the newly registered manager improve the way they monitored the quality and safety of the service people living at the home received.

We saw managers followed up the occurrence of any accidents or incidents involving people living in the home and developed action plans to help prevent them from reoccurring. Examples included routinely reviewing people's risk assessments and management plans that were in place for staff to follow and protect people from identified hazards. Staff gave us several examples of situations where they had used incident reporting to identify trends and patterns to develop risk prevention and management plans which had resulted in a significant decrease in the number of pressure sores people had in the home. The registered manager and unit managers met weekly to discuss clinical issues.

The newly registered manager demonstrated a good understanding of their role and responsibilities particularly with regard to legal obligations to meet CQC registration requirements and for submitting statutory notifications of incidents and events involving people using the service.

People spoke positively about the leadership and management of the service. One person told us, "I've got a lot of time for the nurses who run the units. Always professional, but friendly with it", while a relative said, "I like the new manager. He always makes himself available for a chat if you need him." Staff also said the managers and senior nurses at the care home were supportive and approachable and they felt listened to and valued by them. Several staff frequently described the managers as "approachable" and "friendly". One staff member told us, "I really like the new [registered] manager. He's a nice chap...Really easy going and approachable."

There was an open and inclusive culture at the service in which people, relatives and staff were encouraged to speak with the senior staff team at any time. People and staff were had opportunities to share their views and experiences and managers welcomed their suggestions. We observed numerous occasions where

people, visitors and staff popped in to see the registered manager. The provider used a range of methods to gather stakeholder views which included regular meetings for people living in the home and their relatives, and annual satisfaction surveys. All the satisfaction surveys that had been completed and returned to the provider by people in the past 12 months were generally positive about the standard of care they or their family member had received at the home. Staff attended regular team meetings and were encouraged to participate in an annual staff survey where they could contribute their ideas for how the quality of care and support provided to people could be improved.

The registered manager and staff worked closely with the local authority, clinical commissioning groups (CCG) and various community healthcare services to review joint working arrangements and to share best practice. For example, it was clear from comments we received from a visiting GP, tissue viability nurse and a chiropodist these community health care professionals felt they had good working relationships with the service's management and care staff teams. One health care professional told us, "The nurses are very good at contacting us straight away if they're concerned about a person's health and they always follow my medical advice." Another health care professional said, "The new manager has gained a place on the Health Innovation Network Pioneer Programme, and works closely with us as commissioners."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems to assess, monitor and improve the quality and safety of the care and support people living in the care home received. Regulation 17(2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not operate effective staff recruitment procedures to ensure people living in the care home were not placed at unnecessary risk of receiving inappropriate or unsafe care and support from people who might not be 'fit and proper' or of 'good' character. Regulation 19(1) (2) & (3)