HC-One Limited

Tower Bridge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an inspection of Tower Bridge Care Centre on 30 November and 3 December 2018. The first day of the inspection was unannounced. We told the provider we would be returning for the second day.

At our last inspection on 1, 2 and 9 August 2017, we identified some concerns in relation to the employment of fit and proper persons and medicines storage. We also found the risks to people's physical health were not always identified and managed appropriately and people told us they did not always get care from care workers of the gender they wanted.

Tower Bridge Care Centre 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. Tower Bridge Care Centre provides nursing care, respite and accommodation for up to 128 people over four floors. Two floors are for people with dementia who have nursing needs, one for people who have nursing and end of life care needs and the remaining floor is a residential unit for people who are at the early stages of dementia. At the time of our inspection there were 116 people using the service.

There was a registered manager at the service. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's safety were managed safely, but the level of risk was not always accurately recorded. We identified some examples of where the level of risks were not clearly identified. Repositioning charts were filled in to document when and how frequently people were being turned whilst in bed to minimise the risk of pressure ulcers.

The provider safely administered medicines, but accurate records were not always kept where the GP advised people's medicine to be stopped or where PRN medicines were offered.

The organisation had systems in place to monitor the quality of the service, but these were not always effective as they did not identify the issues we found in relation to risk assessments and medicines management.

Feedback was obtained from people through residents and relatives meetings and this was acted on. There was evidence of further auditing in many areas of care and action was taken to rectify any issues identified as a result.

The provider conducted safer recruiting processes to ensure care staff were safe to work with people.

There were enough staff working in the home. Care staff received appropriate training and ongoing monitoring and support.

People told us they felt safe living at the home. There was an appropriate safeguarding policy and procedure in place and care staff had a good understanding of this.

Good infection control practices were operated throughout the home. We found appropriate and effective action had been taken to conduct appropriate test control within the home.

The provider assisted people to meet their nutritional and healthcare needs. Care records contained a good level of information for care workers to meet these and care workers supported people to access external health professionals when needed.

People using the service were involved in decisions about their care and how their needs were met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
People told us care staff were caring and we observed people being provided with compassionate care. Care staff knew people's likes and dislikes and respected their privacy and dignity. People's cultural and religious needs were met.

There was an effective complaints policy and procedure in place and people told us they felt comfortable raising a complaint where needed.

The provider delivered a range of activities and monitored people's involvement to reduce the risk of social isolation.

People received appropriate support at the end of their lives.

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 consistently safe. Medicines were administered safely in accordance with people's needs, but appropriate records were not always kept.

Risks to people's care were safely assessed in order to manage risks, but some risk assessments did not always accurately record the level of risk. People's repositioning charts were consistently filled in.

The provider operated safer recruitment procedures by carrying out appropriate checks before staff began working at the service and there were enough staff working at the service.

The provider conducted appropriate investigations and consequent learning from incidents and accidents.

Care staff had a good understanding about how to protect people from the risk of abuse and there were appropriate systems and processes to manage this.

The provider operated good infection control practices throughout the home.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service was caring.

People gave positive feedback about the care workers.

Care workers treated people with respect and safeguarded their dignity.

Care workers demonstrated a good level of knowledge about the people they were supporting and helped them to maintain their independent living skills.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider conducted audits in different aspects of service delivery, but these did not identify the issues we found in relation to people's risk assessments and medicines administration.

The provider obtained feedback from people using the service and acted on this.

Notifications of significant events were submitted to the Care Quality Commission as required.

Tower Bridge Care Centre

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.

The inspection took place on 30 November and 3 December 2018. The inspection team consisted of one inspector, two experts by experience, a pharmacy inspector and a specialist advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection the specialist adviser was a nurse with expertise in dementia care. The first day of our inspection was unannounced, but we told the provider we would be returning on the second day.

Prior to the inspection we reviewed the information we held about the service. We spoke with one social care professional and a pest control expert working with the home to obtain their feedback.

During the inspection we spoke with 29 people using the service and four of their relatives. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with nine care workers, two team leaders, three nurses, one activities coordinator, the clinical lead, the registered manager and the regional manager for the provider. We looked at a sample of 15 people's care records, 40 Medicines Administration Charts (MAR), nine staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. People's comments included "I feel very safe, staff look after me" and "They all try very well to make me safe and looked after."

At our previous two inspections we identified some issues regarding the storage of medicines. At this inspection we looked at the medicine administration records (MARs) for 40 people on three different units. At this inspection we found people were being given their medicines safely, but appropriate records were not always kept.

We reviewed peoples' prescriptions and medicines administration records (MARs), and saw evidence that people were given their medicines as prescribed and in accordance with medical advice, but this was not always recorded. For example, we identified one person whose GP had advised their antibiotic to be stopped and another person could not be given their medicine due to the provider being unable to administer it in the manner prescribed. However, this was not recorded on the MAR charts for either person. We also identified another person was not given their morning dose of medicine which ought to have been given at 8am, until 11.45am. The provider ensured the person was safely given this medicine once we alerted them to this omission.

Some people were prescribed medicines to be given only when needed, known as PRN medicines, for example for pain relief, constipation or dry mouth. We saw that staff had PRN administration protocols to inform them when and how these should be administered. However, we did not see consistent evidence that people were given their PRN medicines when needed particularly for people with dementia and those unable to make a request from staff. In some of the units, there was no documentation either on the MAR chart or care plans of PRN medicines being offered. Staff told us that the MAR chart was left blank because people did not require any PRN pain relief. In another unit, we saw that staff were using the Abbey pain scale to assess peoples pain and there was documentation on the MAR chart when PRN medicines were offered and refused, or administered. One person was prescribed PRN oral saliva for relief of dry mouth. The PRN protocol stated that this person was not able to alert staff of their need for this medicine. Nevertheless, we did not see any evidence that the PRN medicine was offered, administered, or that the person's need had been assessed during the last month. We therefore could not be assured that this person was being appropriately assessed for this medicine as needed.

We found processes were in place for the storage, recording and administration and disposal of medicines including controlled drugs. Medicines were stored safely and securely including controlled drugs (CD). Medicines requiring cool storage were appropriately stored and records showed that they were kept at the correct temperature and fit for use. We found prescription charts had additional information included such as allergies, and on occasion, evidence of appropriate medicines reviews from the GP.

There was evidence that people receiving medicines that needed regular blood monitoring and dosage changes such as people with diabetes and those taking anticoagulants were being monitored. We saw appropriate medicine risk assessments in care plans for people taking high risk medicines.

Staff told us how they rotated the sites used for administering medicines supplied in patch form. Records showed that staff responsible for administering medicines had undergone some training including a competency assessment. Staff told us that the GP visited weekly and would regularly review peoples' medicines. We saw evidence that people's medicines were being reviewed.

At our previous inspection we identified a concern in relation to risks involving people's physical health needs. We found care plans did not always specify how frequently people were required to be repositioned, to reduce the risks of pressure ulcers. We also found appropriate records were being kept which stated how frequently people were repositioned. We found there were appropriate skin integrity care plans in place which identified risks and there were detailed risk management guidelines in place. Risk management guidelines stipulated that people were supposed to be turned in order to reduce the risk of sustaining a pressure sore. We found people's skin had improved and this indicated that guidelines were being followed, but we found people's documentation was not being consistently completed to evidence when and how frequently this was happening.

The provider conducted appropriate risk assessments to manage and mitigate risks associated with people's care although we did see some examples where the level of risk of people falling was not always clear.

Where people were identified as being at a high risk of falls, we saw they had an appropriate risk assessment and care plan in place. For example, we saw a falls risk assessment was in place for one person who had a high risk of falling and had a history of falling numerous times prior to moving into the service. We saw the reason for their high risk of falls had been identified. The person had a specific care plan which detailed the risk and management guidelines such as ensuring that the person had specific shoes on when mobilising, that their environment was clutter free and that they were observed when mobilising. However, where people had a risk of falling, but the risk was not high, we did not see clear written information about what the level of risk was. For example, we identified two people's care plans which stated that they had a history of falls, but did not specifically state what the level of risk was. There was some guidance within these documents about how care workers should mitigate the risk of the person falling.

The provider conducted appropriate investigations into accidents and incidents to ensure improvements were made and lessons learned. Where accidents and incidents occurred, the provider completed a DATIX form on their online system. DATIX is a web-based incident reporting system for health and social care organisations. DATIX forms included details of what happened, what actions were taken as a result, whether the person was taken to hospital and the level of seriousness of the incident. For example, we saw one incident which involved a person who sustained a skin tear on their arm. This was not witnessed, but care staff checked the person's room to identify possible causes of the tear and found that the person often retrieved items from their bedside table and there was a sharp edge to this.

Care staff discussed the person's furniture in a multi- disciplinary meeting and discussed putting protective edges on the furniture to minimise the risk of this recurring. This demonstrated that appropriate investigations were undertaken and appropriate action taken as a result.

The provider conducted appropriate risk assessments of the environment to ensure that it was safe. People had a 'safe environment care plan' within their care records and this confirmed that risks were assessed and managed. For example, we saw one person's care plan stated that they needed supervision when moving around. Their safe environment care plan also stated that they needed a clutter free environment to move in and care workers were responsible for ensuring that this was maintained.

Care staff received training in safety systems, processes and practices. Care workers told us they received training in fire safety and basic life support. Care workers had a good understanding of how they were required to respond to emergency situations. One care worker told us "If someone became unwell, I would call the nurse who would assess the situation, or I might call the ambulance right away if I needed to." We saw people had call bells in their rooms and these were within people's reach. People told us they would ring their bells if needed and that care workers responded to these promptly. We also saw that the provider conducted their own checks on a monthly basis and records indicated that call bells were responded to within one minute.

Care records contained advice for care staff in the event of an emergency and personal emergency evacuation plans (PEEPs). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach a place of safety unaided or within a satisfactory period of time in the event of any emergency. We saw people's PEEPs included relevant details such as the number of staff and type of equipment required for the safe evacuation of each person.

At our previous inspection we identified a concern in relation to the way one staff member was recruited. At this inspection we found the provider operated safer recruitment practices to help ensure candidates were safe to work with people. We reviewed nine care workers employment files and found they contained evidence of application forms with people's full employment history, criminal record checks, two references including one from their most recent employer and evidence of their right to work within the UK.

Prior to our inspection we received numerous concerns about mice in the building. At our inspection we found the provider followed appropriate infection control procedures and had taken effective action to remove mice from the building. We spoke with a member of staff from the extermination company commissioned by the provider to handle this issue on the first day of our inspection. They explained the action that had been taken to deal with the mice and this included twice weekly checks and an extensive check of all areas of the building. We spoke with people using the service and they confirmed they had not seen a mouse for at least two months. We conducted the inspection over a period of two days and did not see any mice. Care staff also confirmed that the situation was much improved and they had not seen any mice for some time. One care worker told us "Things are so much better now. I haven't seen a mouse for ages."

We found the provider took appropriate action to maintain a clean and hygienic environment. We found the home was clean and tidy throughout our inspection and was free from odours. We spoke with care staff about how they maintained good infection control and they gave us some examples. One care worker told us "I wear PPE [personal protective equipment] when I'm giving personal care and always wash my hands."

The provider ensured there were sufficient numbers of suitable staff to keep people safe. Care staff told us there were enough staff scheduled to work. Care workers comments included "I think we've got enough staff" and another care worker said "It can get a bit tricky if someone calls in sick, but they try to get someone to come and fill in." We spoke with the registered manager about how they ensured there were enough staff. They told us people's dependency was assessed on arrival to ensure they had sufficient staff to manage their needs. They were placed on units that included people of similar dependency and the registered manager assessed staffing numbers accordingly. We observed that there were enough care staff to meet people's needs and to respond to individual requests throughout our inspection. We reviewed the staffing rotas for the week of our inspection and found the staffing numbers matched those we observed during our inspection.

The provider ensured there were suitable processes in place for the identification and prevention of abuse.

Care workers had a good understanding about the signs of abuse and how to act if they suspected someone was being abused. One care worker told us "We would report anything that was unusual" and another care worker said "You get to know the people living here and can tell if something's wrong." The provider had an appropriate safeguarding policy and procedure in place. This stipulated the process that needed to be followed where an allegation of abuse had been made. The provider was required to investigate the incident and take immediate action to ensure the person was safe. They were also required to report allegations to the local authority for investigation. We spoke with a member of the local authority and they confirmed that safeguarding matters were reported as necessary and they did not have any concerns about people using the service. We found the provider did not have an excessive number of safeguarding matters raised and these were managed appropriately.

Good

Is the service effective?

Our findings

People gave good feedback about the food available. One person told us "The food is something like we would have at home" and another person said the food was "quite good…we get a menu and choice." We sampled the food on the first day of our inspection and found it was appetising, of a good portion size and served at the right temperature.

People were supported to eat and drink and maintain a balanced diet. We saw people's care records included a form called a 'diet notification record' and this included details of people's preferences in relation to food, whether they required a special diet and if they had any particular requests. For example, we saw one person's record gave details of how they preferred their tea and confirmed that they liked to drink this on a daily basis.

Where people had particular nutritional needs, we found these were included in their care records and contained specific details about how care workers should meet these. For example, we found most people had a monthly MUST score recorded. A MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. Where people's score indicated that they were at risk, we found evidence that they had been referred to a dietitian for specialist advice. For example, we saw one person's care record included specific advice from the dietitian requesting that the person take supplementary drinks. Where people were at risk of choking, we saw their care record included choking risk assessments identifying the risk along with clear guidance for care workers. For example, one person's record stated that they required their food to be cut up and another person's care record stated that they were at risk when drinking fluids and were therefore required to use a thickener in their drinks. We spoke with care workers and they had a good understanding of who was at risk and who was not. For example, one care worker was clear about the thickener the person was required to use in their drinks.

Care records included sufficient details about people's healthcare needs and care workers had a good understanding of these. For example, we saw people had oral health assessments within their files to identify whether they needed any specific support in this area. People also had sufficient information included about their mental health needs along with details about whether they took any medicines to manage this as well as triggers for their conditions. For example, we saw one person's record stated that they took specific medicines for managing their anxiety and that care workers were required to be vigilant and observe the person closely, to ensure they did not get confused by explaining matters clearly and encouraging the person to participate in activities. We saw details of other healthcare professionals involved in people's care as well as their contact details.

Care staff had a good level of knowledge about people's healthcare needs. Care workers, team leaders and nurses gave good descriptions of the healthcare needs of people using the service.

The provider ensured that people's care was delivered in line with current legislation and guidance. We spoke with the registered manager about how they ensured people's care was delivered in line with up to date standards and she confirmed that policies and procedures were in place that were updated as needed.

For example, we found the providers infection control policy contained reference to Department of Health – Prevention and control of infection in care homes, an information resource dated February 2013. The registered manager also confirmed that care staff received up to date refresher training that referenced current guidance and legislation.

People told us care staff had the right skills to do their jobs. Their comments included "Every one of them knows everything. They are very well trained, you can tell by the way they do things and check things with each other" and another person told us "The staff know what they are doing, they take time and make us all feel well looked after and safe because they are well trained."

Care workers confirmed they received appropriate induction, training and supervision of their performance. Care workers told us they received an induction that included three days of training in subjects including safeguarding adults, infection control and first aid. Thereafter, care workers received ongoing support in the form of supervisions every three to four months. Care workers told us they found supervision sessions to be useful to their roles. One care worker told us "It's a good way to learn" and another care worker said "It's a good way to take time out and really reflect." Records confirmed that care workers also received an annual supervision. We saw records of these and saw these involved a review of the care workers targets, whether they needed any more training and any other issues specifically relevant to their work.

We reviewed records of training and found care workers received annual refresher training in various subjects including emergency procedures, moving and handling and infection control. We found compliance rates with annual training was over 75% for most subjects. Care workers told us they had enough training to do their jobs and could request extra training when needed. One care worker told us "We get a lot of training and can get more if we want."

Care staff provided people with care in accordance with their valid consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care staff had a good understanding of the need to obtain people's consent before providing people with care. One care worker told us "We always ask for people's consent before we care for people". We observed care staff asking people for their consent before assisting people and people confirmed this was their usual practice. One person told us prior to providing care that care staff "ask for permission" and another person said "The staff explain everything. They take their time and chat to you [whilst they are providing care]."

People's care records included mental capacity assessments which confirmed whether or not people had capacity to make decisions and where they did not, we saw decisions were made in people's best interests. For example, we saw one person's care record confirmed that they did not have capacity to consent to their care. We saw a best interests decision had been made in consultation with the person's family. Where people needed to be deprived of their liberty in their best interests, we saw valid authorisations from the local authority were obtained. For example, we saw one person had bed rails in place and could not leave the building on their own for safety reasons. Their care record contained an authorisation from the local authority that included details of their bed rails as well as their inability to leave the building on their own.

Good

Is the service caring?

Our findings

People gave good feedback about their care workers. People's comments included "They make you feel part of a family, they are such lovely caring people. Staff that are here are angels", "They are in the right job, you can tell how caring they are" and "Very kind. They are here to help us and they seem to love doing that."

At our previous inspection we found people's privacy and dignity was not always respected as people did not always receive care from care workers of their requested gender. At this inspection we found people received care from care workers of the gender they requested and they confirmed this. One person told us "I've asked for women only carers and that's what I get." Care records also stated whether people had a specific preference for a male or female care worker and staff confirmed they respected this.

People confirmed their privacy and dignity was safeguarded and they were treated with respect. People's comments included "The staff are polite", and "They are respectful and considerate." Care workers also gave us examples of how they protected people's dignity, particularly when giving people personal care. One care worker told us "We make sure doors and curtains are closed before we give personal care" and another care worker told us "I would never barge into someone's room, you can see we all knock." We observed care staff knocking on people's doors before entering their rooms and we saw examples of staff being mindful of people's dignity in their appearance. For example, we saw one care worker attentively help someone to cover themselves when they had exited their room.

Care staff had a good understanding about people's preferences in the way they wanted their care to be delivered. They were aware of people's routines, including their bedtime routines and bathing preferences as well as their likes and dislikes in relation to their food and drink. One care worker told us "We know what time people like to go to bed and what they do. For example, I know [one person] usually goes to bed at about 10." We saw people's care records included personalised details about people's personal preferences in relation to their care as well as their routine. For example, we saw all people's records stated how often they liked to receive personal care and whether they preferred having a bath or a shower.

Care records contained some details about people's personal histories. This included details about people's previous occupations, their families and people important to them as well as the circumstances that led to people requiring care. For example, we saw one person's care record contained many details including that they were an only child, that their father fought in the second world war and worked as a factory labourer for the rest of his career. It stated that the person had never married, but been very sociable which care staff were required to encourage through participation in activities.

People were supported to be as independent as they wanted to be. Care workers gave us examples of how they supported people to maintain their independent living skills. One care worker told us "We help people to do things and if they don't need help, we might supervise if that's what they need." People's care records included details of what people could do for themselves and how care workers assisted people in accordance with their needs. For example, we saw people's mobility care plans were clear about exactly what assistance they needed when mobilising and which specific movements they could do independently,

such as transferring from chair to chair or mobilising in the shower.

We observed care staff respecting and acting on people's choices throughout our inspection. We observed care workers offering people choices in relation to their food and drink and waiting patiently for people's response before acting on this. For example, we overheard one care worker offering people different meal options during the lunch time period and showing them the prepared plates of food to assist them in making their choice, before they made up their mind. Care workers told us they offered people choices in all aspects of their care. One care worker told us "If you've got someone who needs a lot of support, you've got to allow them to make their own choices... that way they still have some control."

People were supported to meet their cultural and religious needs. Most of the people using the service were Christian, some of whom were practising their religion. The registered manager confirmed that a weekly church service was provided for those people within the home and an additional weekly communion for practising Catholics. There was one person using the service who practised another religion and we were told that this person conducted their prayers in their room. The provider made further efforts to meet people's cultural needs. For example, we were told that people's cultural requirements in relation to food were met. The registered manager explained that Caribbean meals were provided three times a week to meet one person's needs.

Good

Is the service responsive?

Our findings

People confirmed they were involved in the formulation of their care plans. One person told us "I was part of the care plan."

Care records were personalised and covered different areas of people's needs. Care plans covered people's physical, emotional and social needs. We saw specific details about people's requirements in relation to different areas of their needs and care workers had a good understanding of these. For example, we saw specific recorded details in relation to people's personal care needs. One person's care recorded stated how the person liked to have their hair styled, how they wanted their nails maintained and that they wanted their facial hair to be removed. Monthly evaluations were completed of people's care plans in order to review whether they continued to reflect people's needs and preferences. We saw changes were made when necessary so care plans remained up to date.

People were supported to maintain their recreational interests. The service employed six activities coordinators, four of whom worked part time, to deliver a programme that spanned seven days a week. Activities covered a range of indoor and outdoor activities including visits to popular destinations, pampering sessions, indoor quizzes and movie viewings. On the days of our inspection we saw the provider was running a Bollywood dance session which involved volunteers from an external company attending and holding an interactive dance session. We also saw movies were played on a large screen and this was popular among people using the service.

We spoke with an activities coordinator who told us they obtained feedback from people using the service in relation to activities that were held. They explained that where sessions were unpopular, they made changes to the timetable to ensure they were not held again. The coordinator told us "It's obvious when people aren't enjoying an activity... We just make sure we don't hold it again." Sessions were also held for people who could not leave their rooms. These were one to one activities that could include reading, playing music or taking time to have conversations with people. We reviewed care records and saw people's involvement in activities were monitored on a weekly and monthly basis to reduce the risk of social isolation. Where people were identified as at risk, the activities coordinator stated they held discussions with the team leader or nurse on their unit, to find new activities people could be involved with.

People had communication care plans in place to provide care staff with advice in how best to communicate with people. Care plans detailed whether people had sensory loss that impacted on their ability to communicate, their understanding and comprehension, whether English was their first language and other factors that could impact upon their ability to communicate their needs effectively. For example, we saw one person's care plan stated that they did not have any visual or hearing impairment, but due to their dementia they were sometimes confused when communicating with people. Care workers were therefore advised to speak clearly when communicating with this person in simpler and shorter sentences in order to improve their ability to understand. We observed care staff communicating clearly with people throughout our inspection. They also gave us specific advice when we spoke with people. For example, one care worker explained that one person had difficulty hearing and that it aided our communication if we

faced the person and spoke in a loud and clear voice.

The provider met the Accessible Information Standard (AIS) through providing information to people in a format that they were able to access and understand. The AIS is a national standard that all organisations providing NHS or adult social care are required to implement. The AIS ensures that people using services who have a disability or sensory loss receive information they can access and understand. For example, we found the provider's complaints policy was available in an easy read format and the registered manager told us that other information such as policies and procedures could be made available in either different languages or an easy read format if requested.

The provider had a clear complaints policy and procedure which was followed when responding to complaints. We saw a record of the complaints the provider had received and saw these were investigated and responded to appropriately. The provider's complaints procedure involved a swift investigation of matters within 14 days for formal complaints and an immediate response where possible for low level complaints. Action was taken to conduct necessary follow up actions in response to complaints. For example, we saw necessary and effective action had been taken in relation to the main complaint about there being mice within the building.

People told us they felt comfortable complaining if they needed to. One person told us "I open up to all of them, so I don't need to complain" and another person told us "I don't have any complaints but I could ask them here and they would sort it all."

People receiving end of life care had appropriate plans in place to manage their needs. We found people's records included details such as whether they wanted care staff to attempt resuscitation in the event of a cardiac arrest and this decision was recorded within an appropriately authorised legal document. There was information about people's conditions and what to do if this deteriorated. For example, we saw one person's care record was clear about one their feeding regime and what care staff were to do if the person's appetite decreased. There was also information about anticipatory medicines for pain relief and we saw the provider was prepared in the event of this being required.

Requires Improvement

Is the service well-led?

Our findings

The provider conducted regular auditing of different areas of the service, but we saw these did not identify the issues we found in relation to medicines and risk assessments and therefore there was a risk that these matters would not be addressed which could put people at risk. Various audits were conducted on a monthly, quarterly and annual basis. We saw monthly medicines audits were completed, but these did not identify the issues we found in relation to medicines as there was no analysis of a medicines administration round. Quarterly audits were conducted in infection control, falls and catering. We saw a copy of the most recent audit and found that where areas were identified as requiring improvement, an action plan was put in place and this was reviewed at the next audit. An annual health and safety audit was also conducted. This looked at areas such as whether policies and procedures were in place and whether equipment was checked as required. We saw a copy of the previous audit and saw this did not identify any issues.

The provider also conducted monthly night visits to ensure the care provided at night was appropriate. Various questions were asked as part of this audit, such as whether the home was clean and odour free, whether people appeared well cared for and whether call bells were answered in time. We checked the record of the last night visit conducted after our inspection on 25 December 2018 at 00.10 and the results of this was positive.

Care staff gave good feedback about the registered manager and confirmed they had a good relationship with her. One care worker told us "She is great. She really listens to you" and another care worker said "She is so kind. I had personal problems and she helped me. She always has time and understands how hard we work."

The provider had a clear governance framework that ensured responsibilities were clear. Care workers had a good understanding of what their roles were both within the organisation and in relation to the people they cared for. One care worker told us "It's our role to care for people and to report any issues or changes to their needs" and another care worker said "Ours is the most important job as we're the ones actually providing the care to people." The registered manager was clear about her responsibilities within the organisation, but also received support from her regional manager. This ensured that higher levels of the management team within the organisation were aware of what was happening within the home and that the registered manager support where needed. We saw the regional manager was present throughout our inspection to provide support and guidance where needed.

The law requires that providers of care services send notifications of changes, events or incidents that occur within their services to the Care Quality Commission. The provider was aware of their obligation to submit notifications of significant incidents and we found information was reported to the Care Quality Commission (CQC) as required.

The provider ensured that people using the service were involved as their feedback was obtained and acted on. We reviewed the most recent feedback forms which had been obtained from people in May 2018 and saw the results had been collated. People were asked numerous questions including whether care staff were

kind and caring, whether they liked the food and whether the facilities were appropriate. We saw most people rated the service as average or above in most areas. A separate survey was conducted of relatives of people using the service and we saw they rated the home as good in most areas asked. Appropriate actions plans were conducted as a result and these included timeframes for completion. We were told that residents and relatives meetings also took place every three months. We reviewed the minutes from the most recent meeting which took place in October 2018. We read that discussions were held around different areas of the home including the food, housekeeping matters as well as the care delivered. We saw an action plan was put in place to improve matters that required improvement and there were deadlines in place for the completion of tasks.

The provider worked with other organisations as needed. Care records included details of communications with external healthcare practitioners such as occupational therapists and dietitians as needed. The provider worked in conjunction with the local authority who commissioned most of the care within the home. We spoke with a member of the local authority and they gave positive feedback about their relationship with care staff and the management team.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did consistently ensure the proper and safe management of medicines. 12(2)(g)