Sanderstead Care Centre Limited

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Sanderstead Care Centre is a residential care home providing personal and nursing care to 21 people at the time of the inspection. The service can normally support up to 42 people over three floors in one adapted building, but at the time of the inspection part of the home was closed for refurbishment and its capacity was reduced.

People's experience of using this service and what we found
People were not always safe from avoidable harm because risks were not always managed well. Staff did not always follow risk management plans and some equipment designed to reduce the risk of people developing pressure ulcers was not being used effectively. People did not always have call bells within their reach. Medicines were not always managed safely because there was not always enough information about medicines prescribed to be taken only when needed, records were incomplete and some stock records were inaccurate. The provider did not always adhere to safe recruitment practices and some staff were working without all of the necessary recruitment checks having been made.

The provider did not always comply with their legal duty to notify us of incidents where alleged or suspected abuse took place between people who used the service. Quality assurance checks were not always effective as they did not identify all the issues we found, for example with medicines management.

Staff generally treated people with respect, but occasionally omitted to explain to people what they were about to do while carrying out care tasks so there was a risk of people feeling disempowered. We also found care plans were not always as personalised as they could be, which could also contribute to this risk as people may not always be able to express their preferences to staff.

We have made two recommendations about researching person-centred care and how to improve the quality of interactions between staff and people.

The provider carried out checks to make sure the home environment was safe and staff knew how to protect people from the spread of infection. There were enough staff to care for people safely. The provider recorded and dealt with incidents appropriately. There were systems in place to protect people from the risk of abuse.

The provider was in the process of refurbishing the home and had made improvements to adapt the environment better to people's needs. People's needs were assessed in line with current guidance. Staff worked alongside healthcare providers to support people to keep healthy, maintain a healthy weight and eat and drink enough, although the variety of food was not always good for people who needed a pureed diet. Staff received appropriate training and support, and there were opportunities for them to develop their skills. The provider obtained people's consent before carrying out care and treatment, or if people were unable to consent the provider followed the correct legal processes to make sure decisions made on their

behalf were in their best interests. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff developed good relationships with people and created a friendly atmosphere in the home. They supported people to express their views and make choices about their care. Staff respected and promoted people's privacy, dignity and independence.

Care plans contained information about people's care and support needs. The provider had improved these since our last inspection and had carried out work to ensure staff were well equipped to provide good quality care to people at the end of their lives. There was a variety of activities on offer and we received mixed feedback about these but the registered manager was in the process of taking steps to improve this. People received information in suitable formats and there was an appropriate process in place for responding to complaints.

The provider promoted a positive culture and staff worked well as a team and with other providers. There was visible leadership and the registered manager was supportive and approachable. The provider attempted to engage people and their relatives and involve them in the running of the service, and was looking at how they could do this better.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 March 2019) and we found two breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not made sufficient improvements and was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staff recruitment and notification of incidents. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-led findings below.

Sanderstead Care Centre Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of an inspector, an inspection manager 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.

Service and service type
Sanderstead 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service including previous inspection reports and notifications the provider is required to send to us about significant incidents that take place at the service. We used the information the provider sent us in the provider information return. This is information providers are

required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also spoke with representatives from the local authority safeguarding and commissioning teams. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service, one relative, four members of staff, the registered manager and a senior manager. 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. We also looked at six people's care plans, four staff files and records related to the management of the service such as incident records.

After the inspection
We reviewed additional evidence we had asked the registered manager to send to us. This included some electronic care records we were unable to view during the inspection due to time constraints.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection in December 2018 we found risk assessments were not always thorough enough to cover all significant risks, particularly around behaviour that challenged. The provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had not made sufficient improvements.

● Risks to people's safety were not always managed well. One person told us, "I use a frame because one of my legs doesn't work well." Although the frame was within the person's reach, we noticed their footwear was substantially damaged, which could have contributed to an increased risk of falls. The person's care plan stated staff were to ensure the person was wearing appropriate footwear at all times. Another risk assessment stated that the person's drinks needed to be thickened because of a choking risk, but the drink staff brought to them was not thickened and the person told us they habitually drank the tap water from their bedroom as they were not provided with thickened drinks to keep there. We were concerned there was a risk of this person choking on liquids, particularly while alone in their bedroom.
● We also found the risk of people developing pressure ulcers was not always well managed. Staff regularly checked the settings on mattresses that were designed to reduce the risk of people developing pressure ulcers. However, the checks did not show what the setting of each mattress should be or whether it was correct, so we could not be sure whether the checks were effective. We checked some of the settings against people's weight records and found two of the mattresses we checked were at the wrong setting for those people's weight, meaning the equipment designed to protect them was not being used effectively and those people may therefore have been at increased risk of developing pressure ulcers.
● There were systems and facilities to keep people safe in emergencies. The home used a telemedicine service, which allowed staff to speak to medical professionals immediately over video calling if a person's health deteriorated. Staff told us this helped them keep people safe during medical emergencies but also reduced the number of hospital admissions. However, one person who was unable to leave their bed did not have their call bell within reach and we were concerned they would be unable to alert staff in an emergency. Another person's risk assessment stated they were unable to use a call bell in an emergency but there was no information about what measures were in place to reduce risks associated with the person being unable to call for help.
● Staff checked regularly to make sure the home environment was safe. Flooring that was uneven and could have caused trips and falls had been replaced since our last inspection and was now safe.

Using medicines safely

At our last inspection in December 2018 we found medicines were not always managed safely. Records did not always correspond with the amount of medicines in stock, meaning there was a risk that people did not always receive their medicines as prescribed. Medicines were not always stored safely. The provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we continued to find problems.

● Where people had medicines prescribed to be taken when needed, guidance for staff was not consistently available. Some people had no information about why the medicine might be needed or safe dosage levels. Others had this detail but no information about how people may show they were in pain, for example.
● The codes used by staff to complete medicine administration records (MAR) were confusing because staff had not written them clearly. One staff member's signature matched one of the codes in use, so it was not possible to easily see whether people had received their medicines as prescribed. Records about refused or destroyed medicines were incomplete, creating the opportunity for error.
● The registered manager told us about improvements they had made to medicines management since our last inspection. Nurses carried out daily stock checks and the deputy manager completed an additional weekly check. However, we found the amount of medicines in stock still did not correspond with what records indicated should be present. In at least two cases there were more tablets than there should have been based on MAR, which suggested people did not always receive their medicines.
● The temperature of the medicines room and fridge were regularly monitored and recorded to ensure medicines were stored appropriately. Medicines were mostly stored appropriately, although some topical medicines had been left in a communal bathroom meaning there was a risk of them being used by people other than those who were prescribed them.
● People told us they received their medicines as prescribed. One person mentioned they sometimes needed painkillers, which staff brought when they asked for them.

The issues we found with risk management and medicines management meant the provider continued to be in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Recruitment processes were not consistently safe. Out of four recruitment files reviewed, two contained all necessary checks and documents. In the remaining two files, one reference had not been obtained from the most recent employer, even though the staff member had highlighted a possible issue with that employment. This had not been followed up to make sure this staff member was suitable to be employed in the service. Another staff member's reference gave different employment dates than shown on their application form. This had not been picked up or investigated by the provider and meant there was a gap of eight years with no explanation in the staff member's employment history.

The lack of consistently robust recruitment processes is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to care for people safely. The provider used a specialised tool to assess each person's needs in terms of how much support they needed from staff daily. This included the support they needed to eat and drink, for personal care and other daily activities. The registered manager told us the tool allowed them to assess staffing needs flexibly as it was easy to update when people's needs changed. They also used the tool to identify the provider's needs in terms of staff recruitment.

Learning lessons when things go wrong

At our last inspection in December 2018 we found at least one significant incident was not recorded properly, which meant the provider's system for learning lessons from incidents would not always be effective. This formed part of the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we did not find evidence of any significant incidents that had not been recorded.

● There was an adequate system in place for recording and learning from incidents.
● The provider carried out pieces of work to enable them to learn lessons from specific types of incidents. For example, they completed a monthly falls audit to look for any patterns and trends in falls. They took appropriate action in response to data indicating an increased risk for individuals, such as referring people to physiotherapy services or installing safety equipment in their bedrooms.

Systems and processes to safeguard people from the risk of abuse
● There were policies and procedures designed to protect people from the risk of abuse. Staff knew about these and knew how to report and escalate any concerns. People told us they felt safe using the service.
● The provider dealt appropriately with any suspected or alleged abuse reported to them. This included keeping clear records, reporting to local authority safeguarding teams and carrying out investigations.

Preventing and controlling infection
● The home was visibly clean and free of unpleasant odours. Staff completed daily cleaning checklists and there were regular deep cleans to ensure the environment remained hygienic. The registered manager told us they had recently replaced carpets with vinyl flooring that was more hygienic as it was easier to clean and less likely to harbour harmful bacteria and unpleasant odours.
● Staff knew how to reduce the risk of infection by, for example, testing the temperature of cooked food, using approved hand washing techniques and wearing personal protective equipment (PPE) at appropriate times.

Requires Improvement

Is the service effective?

Our findings

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

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

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

At our last inspection we made a recommendation that the provider made some improvements to the environment so it was better adapted to meet the needs of people living with dementia. At this inspection the provider was in the process of doing this and part of the home was closed for refurbishment as part of the provider's improvement programme.

- Parts of the home were decorated in pleasant colours, with plans in place to extend this to the rest of the home. The registered manager told us they had researched best practice in providing an adapted environment for people living with dementia. There were adaptations designed to assist people living with dementia, such as orientation boards with information such as the current date and weather.
- The home had adaptations to allow people with reduced mobility to move around freely and use the facilities safely. For example, there were wide corridors, grab rails and raised flowerbeds so people could do gardening activities.

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

- We received mixed feedback about the quality of the food, although most comments were positive. One person said, "The food is beautiful here. My favourite is curry." However, another person told us they only got to eat soup and yogurt because they needed a soft diet, but were not offered other foods in pureed form. We saw staff offering the person soup and yogurt but not any other foods. The registered manager was aware feedback had been mixed, had carried out a catering audit the week before our inspection and was considering how they could further improve catering.
- At our last inspection, we noted people were waiting 20 minutes or more, and in at least one case over half an hour, between being seated at dining tables and receiving their meals. We were concerned about the potential impact on people's mealtime experience. At this inspection, we observed the delay between staff supporting people to take their places at dining tables and receiving their food had reduced, but was still significant. People waited more than 15 minutes at tables and one person waited 23 minutes to receive their food. This had an observable impact on some people, for instance one person who showed signs of agitation, shouting out at regular intervals until their meal arrived and they appeared to calm down.
- Staff monitored people's weight to ensure they had enough to eat. Where people were underweight, had lost a significant amount of weight or were otherwise at risk of malnutrition, staff monitored what they ate, referred them to other services if necessary and supported them to make adjustments to their diets such as taking nutritional supplements.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had an assessment of their needs, which was used to plan care in line with guidance.
● The registered manager regularly checked to make sure assessments were completed properly so staff had the information they needed to provide effective care.

Staff support: induction, training, skills and experience
● Staff had opportunities to build and develop their existing skills. Some staff were trained as clinical support workers, which meant they had additional training and could carry out some clinical tasks such as administering medicines and taking blood. This in turn gave the qualified nurses more time to carry out more complex nursing tasks with people.
● There was a variety of training for staff, which covered the needs of people currently using the service. Staff told us they received good quality training and a thorough induction when they started, which was tailored according to their previous experience and knowledge.
● Staff received the support they needed to do their jobs well. They regular met with their supervisors to discuss their work and any issues they were having. Staff told us they were happy with the support they got from the management.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with mental health services to monitor any changes in people's behaviour that might be cause for concern. Staff used behaviour monitoring charts for some people and checked them weekly. They reported concerns promptly to the GP and psychiatrist where appropriate.
● The registered manager told us they worked closely with a pharmacist to make sure people received the support they needed with medicines.
● People confirmed they were able to access healthcare services when they needed to. One person's relative said their family member had received good support from the home when they returned from a hospital stay.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● The provider checked people's capacity to make decisions about their care, in line with the law. If people did not have capacity to consent to decisions about their care, the provider arranged for DoLS to be put in place where appropriate. There was evidence that the provider took the necessary steps to ensure decisions made on people's behalf were made in their best interests. This included asking relevant people, such as family members, medical professionals and social workers, to take part in the decision making process.

- People who had capacity consented to the care they received and this was recorded in their care files.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● Staff usually treated people with respect, but occasionally did not keep people informed of what they were about to do when performing care tasks. This can lead to people feeling disempowered or less involved in their own lives. For example, we observed staff moving a wheelchair in which a person was sitting on several occasions without first speaking to the person about what they were about to do. On another occasion, a member of staff used their hand to sweep crumbs from a person's chair and leg without explaining what they were doing. We observed the person becoming agitated and slapping the staff member's hand away.

We recommend the provider seek advice from a reputable source on how to improve the quality of interactions between staff and people and ensure staff understand how to provide care in a person-centred way.

● Despite this, most of the interactions we observed were positive and the home had a friendly atmosphere. One person told us, "We have a laugh and a joke. It's a very happy place." We saw staff chatting, smiling and socialising with people. The registered manager regularly checked to make sure staff were interacting with people in positive ways.

● People told us they had developed good relationships with staff. They confirmed there were regular staff they knew well. One person said there were "nice ladies on the staff. They treat us good and nice." A relative told us, "The staff are always polite to [relative] and to us when we come in." Staff took the time to get to know people, collecting information about their life histories, interests and what was important to them when they began using the service.

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

● People were able to make decisions about their daily routine. One person told us, "I decide when I have a shower." However, they also told us there was only one shower and its placement was not convenient for everyone, meaning their choice about when to shower was occasionally limited. We discussed this with the registered manager, who told us the provider was planning to install new facilities within the next few months. People confirmed they were able to choose what time to go to bed.

● Staff gave examples of how they supported people to make choices if they were not able to express themselves verbally. This included offering a visual choice between two items and closely observing people's body language.

● People were involved in planning their care. There was evidence in care plans that people were asked for

their opinions and about their care preferences.

Respecting and promoting people's privacy, dignity and independence
● People told us staff respected their privacy and always knocked before entering bedrooms, although one person said staff did not always wait for a reply before coming in.
● Staff supported people to attend to their personal hygiene and maintain a dignified and well-kempt appearance. We observed one person kept admiring their freshly painted nails, which staff told us they supported the person with regularly as they took pride in it.
● Staff were aware of how to respect people's privacy and dignity, and ensured they provided care in a way that promoted this. They told us they made sure people were comfortable when they completed intimate care tasks and closed doors and curtains to ensure privacy before proceeding.
● Staff monitored people who were up at night time to ensure they did not accidentally enter other people's bedrooms and compromise their privacy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Since our last inspection the provider had made improvements to care plans. They contained enough information about people's needs and preferences for staff to be able to meet their basic care requirements, although in places the care plans could still be more detailed and personalised. For example, some care plans stated staff should encourage people to take part in activities they enjoyed, but there was little or no information about what these activities were. In other cases, care plans mentioned diagnoses of mental illness but it was not always clear how these disorders affected people from their own perspective. People told us the care they received met their needs, however. One person said, "I am comfortable living here."

We recommend the provider carry out additional research into person-centred care planning.

● The registered manager carried out regular checks of care plans to make sure people's care remained responsive to people's needs. This included checking care plans covered people's needs in relation to activities, food and drink, continence, skin care, health needs and whether people were involved in planning their care.

● The provider used an electronic care planning system, which staff told us helped them respond better to people's needs because all the information they needed was stored in a well-organised and easily accessible way.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● We received mixed feedback about activities, most of which was positive. One person said, "I enjoy playing cards and bingo here in the lounge," but another person's relative told us, "We do puzzles and other things with [relative] as when we come in, she is just sitting in the lounge not doing anything." Although there were activity timetables up, these were out of date and not showing activities that were due to happen the week of our visit. Staff informed us the home's activities coordinator was on long-term leave. The registered manager told us about a local service that had begun a project with the home supporting staff to engage people in meaningful activity.

● People were able to maintain relationships with their families and others who were important to them. One person told us, "My family can come in when they like." Another person told us they had support to practise their religion and faith leaders came to the home regularly to lead services.

● Staff made an effort to engage people in activities. We observed some people joining in with these, although staff had to work harder to convince others to participate. Some people told us they would like to try some activities outside of the home, such as trips to cafes, but the home was not always able to facilitate

this.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff were able to obtain information in suitable formats for people, such as large print or translated copies of documents. The registered manager regularly checked to make sure this information was available to people.
● Information was displayed in accessible formats around the home about important topics such as safeguarding, how to complain and information about people's rights.

Improving care quality in response to complaints or concerns
● The registered manager used complaints and concerns to improve care. They used a complaints management tool to identify any trends and themes in complaints. This showed the complaints they received in 2019 were all unrelated and there were no apparent themes, but each complaint had led to an action plan for improving the area of care and support the person had complained about.
● Staff told us they were confident to raise concerns and felt the service was continually improving as a result of the registered manager listening to these.

End of life care and support
● Staff had the knowledge they needed to provide good quality end of life care in line with current best practice guidance. The service worked with a local hospice, which provided support, training and best practice advice around end of life care. They arranged for professional speakers to visit the service to give talks about relevant topics to staff.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection in December 2018 we found the provider had not always notified us of significant events in line with their legal requirements. This included notifications of applications to deprive a person of their liberty under DoLS and of allegations of abuse. The provider was in breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. At this inspection, incidents had not always been properly recorded or notified to CQC. It is a legal requirement that certain events and incidents are reported to CQC without delay. This information helps CQC monitor services and decide when we should inspect.

● Although some accidents had been recorded, fully investigated and notified by the registered manager, a number of incidents between people using the service had not been reported to us. These included acts of aggression, violence or sexually inappropriate behaviour which we needed to know about so we could properly fulfil our monitoring function.

The failure to notify CQC is a continued breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● Staff worked well as a team. They completed a daily shift reflection log where they recorded any concerns they had or things to think about, and had opportunities to discuss these. Staff told us nurses and clinical support workers communicated well and this helped them work as a team.

Continuous learning and improving care

● The provider's quality assurance checks were not always effective. A medicines audit two weeks before our inspection found no issues with medicines management and no discrepancies in stock numbers. This did not agree with what we found at this inspection. The issues we found also showed the provider had not made sufficient improvements after our last inspection and therefore was still in breach of the same regulations.

This failure to effectively monitor and improve the quality of the service was a breach of Regulation 17 (Good

governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager carried out regular checks to make sure other aspects of the service was safe and quality targets were met. This included staff knowledge and training, safety of the premises and equipment and whether care documentation was up to date. Checks carried out in January 2020 showed issues identified in the December 2019 checks had been resolved.
● The provider regularly reviewed accidents and incidents and used learning from these to improve the quality of the service. They also looked at items such as deaths, falls and complaints in more detail to check whether there were any trends that might indicate issues with the safety and quality of the service.
● The provider regularly visited the service to check the quality of the service and make sure the registered manager's checks were complete. This included checking records were complete and up to date, and making sure the registered manager had all the support they needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager told us about work they had done since our last inspection to promote a positive, cohesive culture within the staff team. They felt the staff were working better together as a result. A member of staff told us the manager was "flexible, approachable and fair."
● Leadership in the home was visible. People knew who the manager was and told us they were able to speak with her when they wished. One person said, "She is very helpful. We can ask to see her if we have any concerns or questions and we have." The registered manager regularly walked around the home to check people were happy and receiving the care they needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A relative told us the home had repeatedly attempted to engage people and relatives, but had struggled with this because of poor attendance at meetings and low response rates to surveys. The registered manager had also noted this and had started to encourage people and relatives more to take part. They were thinking about ways of making surveys and meetings more appealing, so they could gather people's views and engage them more in developing the service.
● The provider had developed other ways of gathering people's feedback. This included one-to-one meetings between people and their key workers, where people were asked for feedback about the care and support they received.

Working in partnership with others
● The service worked well in partnership with healthcare providers and other expert advisers to plan and deliver care and assure aspects of care such as end of life care and support for people whose behaviour challenged the service were of good quality.
● The provider communicated well with local authorities and other organisations they needed to share information with.

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 17 HSCA RA Regulations 2014 Good governance The provider did not effectively operate systems or processes to assess, monitor and improve the safety and quality of the service. Regulation 17 (1)(a)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not effectively operate recruitment procedures in such a way as to ensure to the best of their ability that persons employed for the purposes of carrying on a regulated activity were of good character, including obtaining the information specified in schedule 3 of the Act. Regulation 19(1)(a)(2)(3)(a)