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

Summary of findings

Overall summary

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 care home accommodates up to 42 people over three floors in one adapted building. At the time of our visit there were 28 people using the service, some of whom were living with dementia. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. This was the service's first inspection since being taken over by a new provider in February 2018.

We found the provider was in breach of the regulation in relation to safe care and treatment. This was because medicines were not always managed safely and some risk assessments were missing information. Stocks of medicines did not always correspond with what was recorded. We found some risk management plans did not contain important information about how to respond to people presenting aggressive or threatening behaviour.

The provider was also in breach of the regulation in relation to notifying the Care Quality Commission of any outcome of an application to deprive a person of their liberty and to notify us of any abuse or allegation of abuse. Since the inspection, the provider has submitted notifications to us. However, the provider remains in breach of this regulation because they need to demonstrate compliance with this regulation over a period of time.

You can see what action we told the provider to take at the back of the full version of the report.

People felt safe using the service and staff were aware of the service's policy and procedures on safeguarding people from abuse. Risks to people's safety were mostly managed appropriately, including risk of falling, developing pressure ulcers and risks relating to use of mobility equipment. The service had appropriate measures in place to deal with emergencies including fire and medical emergencies. Maintenance staff made sure the premises were safe by carrying out regular checks and minor repairs. The home was clean and there were systems to prevent the spread of infection.

The provider had systems to monitor accidents and incidents. We found evidence the registered manager took appropriate action in response to accidents and incidents.

Medicines were stored safely. There was appropriate guidance for staff about using medicines that did not require prescriptions. People who had medicines to take only when required had instructions for staff about when to give it, although these sometimes lacked details such as how to tell if a person was in pain.

The provider was in the process of refurbishing the home. Some areas looked fresh and pleasant but others

still needed to be refurbished. The service was fully wheelchair accessible but did not have dementia-friendly features such as signage or contrasting colours. We recommend that the provider incorporates best practice guidance about providing a dementia-friendly environment into their ongoing plans for refurbishing the premises.

The registered manager made sure they kept up to date with current research and best practice and passed this on to staff. Some staff were qualified to train their colleagues and staff received a variety of training and supervision to ensure they had the support, skills and knowledge to carry out their roles effectively.

People had their needs assessed in line with current guidance and staff involved healthcare professionals in developing care plans to meet people's healthcare needs. People were able to access healthcare services when they needed to. People's nutritional needs were met and they had access to a variety of healthy, culturally appropriate foods. They received the support they needed to eat and drink although sometimes people had to wait a long time in the dining room before receiving their meals.

Staff obtained people's consent before providing care and where this was not possible they acted in line with the Mental Capacity Act (2005) to provide care that was in people's best interests. This included where people were deemed to have been deprived of their liberty.

People received care from staff who were kind and empathetic and took time to get to know them. Staff made sure people had the information they needed to make choices about their care and adjusted their style of communication to fit different people's needs and abilities. Staff provided care in ways that promoted people's dignity and independence and respected their privacy. Confidential information was kept securely at all times.

People had care plans that contained information about the support they needed. Some people had information missing about how staff could tell if they were becoming unwell. There was a risk that staff who did not know the people well would not know how to respond. However, there was person-centred information about how to support people according to their preferences. People were involved in planning their care.

Some people felt activities could be more varied or better tailored to their interests. However, we saw people enjoying several activity sessions. Staff took steps to protect people from the risk of social isolation and people's religious and cultural needs were met.

The service had a robust complaints procedure and people felt confident raising any issues they had around their care and support. Staff listened to people and responded quickly to any minor concerns.

We received positive feedback about the registered manager, who was well liked by people and staff. The manager worked to promote a person-centred and inclusive culture within the home. People, relatives and staff had opportunities to feed back their opinions about the service. Their suggestions were incorporated into the provider's plans for improving the service.

The provider used a number of audit tools to check the quality of the service. These were effective in identifying areas for improvement. Because these were only identified recently and because this was the service's first inspection under the current provider we could not easily check if the provider's systems were effective in terms of taking prompt action and driving improvement. We will check this at our next inspection.

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. Medicines were not always administered in line with medical advice and were not always recorded clearly. Some risk assessments lacked information about how to protect people and others around them from harm.

There were systems to ensure the premises and equipment were safe to use. Accidents and incidents were managed appropriately.

There were enough staff to care for people safely.

People were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective. Some aspects of the premises were not suitably adapted for people using the service.

People had to wait long periods to receive food. However, the food they received was suitable and their nutritional and healthcare needs were met.

Staff received support to provide care in line with best practice and current guidance.

There were systems to ensure people only received care they had consented to or was in their best interests.

Is the service caring?

Good

The service was caring. People received support from staff who were kind and empathetic.

Staff made sure people had the information they needed to make choices about their care. They knew how to communicate with people in ways they understood.

Staff respected people's privacy and cared for them in ways that promoted their dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always effective. Some important information about how to support people was missing from care plans. However, other information in care plans was person-centred and detailed. The provider sought appropriate guidance about how to care for people approaching the end of their lives.

People told us they would like a better variety of activities.

People and their relatives knew how to complain and there was a robust procedure for managing complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led. The registered manager did not always notify CQC of incidents they are required to report to us about.

People and staff fed back positively about the registered manager and told us the service was well-led. There were opportunities for people, relatives and staff to feed back their opinions of the service.

The provider had effective systems for checking the quality of the service and identifying areas for improvement. We will check their progress with the improvements at our next inspection.

Sanderstead Care Centre Limited

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 20 December 2018 and was unannounced. It 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.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Before the inspection we looked at information we held about the service. This included a provider information return (PIR). The PIR is a document we ask providers to complete to tell us about the service and any improvements they are planning to make. We also looked at other information the provider had sent to us such as notifications they are required to send when significant events take place.

During the inspection we observed how staff cared for people and we used the Short Observational Framework for Inspection (SOFI). This is a method of observing and recording the experiences of people who are not able to express themselves verbally. We spoke with eight people who used the service, two relatives of people who used the service and five members of staff. We also spoke with the registered manager and a senior manager. We also contacted commissioners and other professionals who work alongside this service to gather their views and received replies from four professionals. We checked eight people's care plans, eight staff files and other records relevant to the management of the service such as audits and staff rotas.

Requires Improvement

Is the service safe?

Our findings

Risk assessments did not always cover individual risks to people, particularly with regard to behaviour that challenged. When we arrived at the home, staff advised us to approach one particular person with caution because they had a history of behaving in an aggressive manner. Incident records confirmed this. However, their risk assessment read, "no concerns with interaction [with others]" and there was no information about aggressive behaviour. The person's care plan did not contain any guidance for staff about triggers and warning signs or how to respond if the person became aggressive. Their care plan stated that they sometimes presented behaviour that challenged but did not specify what the behaviour was. Although the provider showed us evidence that this was recorded in challenging behaviour reports and staff were aware of the person's history, new staff would not always have access to this information. This meant there was a risk that staff, especially those who were new to the person, would not know how to keep the person or others safe if they became aggressive.

One person's assessment and medicines administration record stated they should not receive the flu vaccine because of an allergy. Care records showed the person had received the vaccine this winter. Staff told us this was because the nurse on duty made an error when instructing healthcare professionals about who should receive the vaccine. Although there were fortunately no ill effects on this occasion, the impact of administering medicine to a person who is allergic to it may potentially be very severe. However, we did not find an incident report or any other record showing this error had been identified. This meant the provider did not have the information they needed to take action to prevent this from happening again. The provider contacted us after the inspection with evidence that they had addressed this concern and we will check this again at our next inspection.

Other accidents and incidents were recorded using appropriate systems. Where these identified trends, for instance if a person had multiple falls within a short period of time, the provider took suitable action such as updating risk management plans and ensuring they were communicated to staff.

We found one person's medicine to be taken only when required had one dose less than records indicated it should have. This suggests staff omitted to sign on one occasion after giving the tablets, which could potentially have led to overdose if another member of staff had given the medicine not knowing the person had already received it. A third person's blister pack contained one dose more than records indicated it should. Staff investigated this and determined the person had received a dose from a different pack on one occasion but because this was not recorded properly it could also have potentially led to a double dose error. A fourth person's medicine was in a blister pack but one blister still containing tablets had been accidentally broken and not resealed. There was a risk of the tablets going astray or being damaged by exposure to air. We alerted staff who resealed the pack with a sticker.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "I am looked after" and "It's the best place in the world." Relatives felt the service was safe.

One said they had "no worries" about their relative's care. The service had a clear policy and procedure on protecting people from abuse. Staff were trained in safeguarding and were aware of their roles and responsibilities. Records showed the provider responded appropriately to allegations of abuse and neglect.

Other than those identified above, risks were appropriately assessed and managed. Another person with a history of behaviour that challenged services had a detailed risk management plan including suggestions of conversation topics staff could use to distract or divert the person. Risk assessments people had included falls, developing pressure ulcers, using bed rails and using mobility equipment such as walking frames and hoists. These risks were managed appropriately and we saw evidence that staff checked pressure mattresses and cushions daily to reduce the risk of people developing pressure ulcers. Staff we spoke with knew how to protect people from the risk of pressure ulcers and how to respond to medical emergencies. People had personalised emergency evacuation plans. These contained detailed information about people's ability, level of comprehension and what support they would need if they had to evacuate the home.

We noted in some parts of the home surfaces such as linoleum floors were damaged, which presented a potential infection risk as staff would not be able to clean the damaged surfaces thoroughly. However, the premises were visibly clean and there was a detailed daily cleaning regime in place as well as a six monthly deep cleaning schedule to help ensure staff kept the home clean. Staff were aware of their duties in relation to infection control and had access to equipment such as gloves and hand washing supplies to help prevent the spread of infection. There were systems to prevent dangerous bacteria breeding in water supplies and pest control arrangements were in place. The service had regular food safety inspections. The kitchen was clean and tidy, although we did find a package of meat in the fridge that had passed its use-by date. Kitchen staff explained this was because the meat had been taken from the freezer to defrost in the fridge but could not demonstrate awareness of principles of maintaining safety of defrosted food because they had not labelled it with the date it had been frozen or the date it was taken out of the freezer. The kitchen staff said they would make sure frozen and defrosted food was appropriately labelled in future.

The service had maintenance staff who ensured the premises were safe and there were appropriate arrangements in place to cover any emergencies. This included regular checks of fire safety equipment, fire drills and fire alarm tests. The provider ensured equipment, including fire safety and mobility equipment, was regularly serviced by appropriate professionals. Windows were restricted to prevent falls from height and maintenance staff checked these regularly. They also checked to make sure water was at a safe temperature. Records showed where water outlets were running too hot the provider took prompt action to have them adjusted to protect people from the risk of scalds. To help ensure the premises were safe, the maintenance staff kept a log of any repairs needed around the home. Records showed they resolved issues within an appropriate timescale.

The registered manager told us they set staffing levels according to people's assessed needs. Although some people felt there were not always enough staff at weekends, rotas showed the minimum staffing levels were met and there were enough staff to care for people safely. The provider used appropriate checks to reduce the risk of employing unsafe or unsuitable staff to care for people. This included criminal record checks, references and checks of applicants' identity and fitness to work. However, we noted some staff had gaps in their employment records that were not explained. Providers are required to obtain an adequate explanation for any gaps in the employment history of staff members. The registered manager told us they would obtain this information.

There were systems for ensuring that medicines, including controlled drugs, were stored securely and at appropriate temperatures in accordance with best practice guidance. There were adequate stocks of

medicines and staff checked these regularly. The service had appropriate protocols for the use of homely remedies. Homely remedies are medicines that people can buy without a prescription. People who were prescribed medicines to take only when required also had protocols to inform staff when it was appropriate to administer the medicines. However, these were not always detailed. For example, one protocol stated the person should receive a prescribed painkiller when they were in pain but there was no information about how the person, who was not able to communicate complex information verbally, indicated they were in pain. Staff were able to describe how the person's behaviour changed when they were in pain but because this was not documented there was a risk that staff who did not know them so well would not give them the medicine when they needed it.

Requires Improvement

Is the service effective?

Our findings

At the time of our inspection one floor of the house had recently been refurbished and the provider had plans to do the same throughout the rest of the home, although the RM told us there were no definite timescales as the work was ongoing. The home was decorated for Christmas, which showed the provider had considered people's cultural and religious needs with regard to the home environment. Although the home was wheelchair accessible with refurbished communal spaces and a pleasant outdoor area, some aspects of the environment were not adapted to meet people's needs. A healthcare professional told us people were unable to lock their bedroom doors and this had caused at least one person to feel unsafe. The upper two floors of the home were in urgent need of refurbishment. We saw worn and dirty carpets, scuff marks on walls, chipped paint and damaged woodwork. This meant people did not have as pleasant and comfortable a living environment as they could have. The registered manager told us they were also planning to make some changes to make the environment more dementia friendly, for example by adding signage and different coloured doors to aid orientation, but this was not in place at the time of our inspection including in the recently refurbished part of the home. The information on display, such as activities timetables, did not include pictures, symbols or other visual aids to help people with cognitive or sensory impairments to understand the information.

We recommend that the provider incorporates best practice guidance about providing a dementia-friendly environment into their ongoing plans for refurbishing the premises.

Details of people's nutritional needs were in their care plan and staff monitored the food and fluid intake of people who were at risk of dehydration or malnutrition. People were given generous helpings of food which was of good quality. One person told us they preferred spicy food because of their cultural background and said they received this. We saw the person was given an alternative menu of food from their culture. People who needed support to eat got the assistance they required. However, we observed that people had to wait a long time to be served meals. Two people sat at dining tables for more than 20 minutes before they received food and another person waited more than half an hour. By the time they received their food these people were visibly tired and dozing in their chairs. Tiredness could affect people's appetites and make them less inclined to eat full portions.

People's care needs were assessed using information from doctors, social workers and other professionals who worked with people to help ensure care plans were based on appropriate guidance. One person told us, "I can see a doctor if I don't feel well." Nursing staff had systems to monitor the symptoms of people with long term health conditions and knew when to make referrals to the relevant healthcare professionals. Records showed that staff monitored any changes in people's health and wellbeing and people received support to access healthcare services when needed. This included doctors, dentists and specialist nursing services.

The provider used a number of sources to help ensure they were up to date with current guidance including reading updates and attending forums. The registered manager told us the service was working towards Gold Standards Framework accreditation. This is a scheme that supports services to provide good care for

people at the end of their lives in line with best practice. The service was also due to take part in a project a local hospice was planning to start at the beginning of 2019 to enable care homes to support each other by sharing ideas and discussing best practice. We saw evidence that the provider used staff meetings to keep staff up to date about best practice and monitor their knowledge. The service had "champions," who were members of staff who took the lead on ensuring good practice in specific areas and sharing their knowledge in staff meetings.

Staff told us they were happy with the support they received, particularly the training which they said was "brilliant." Records showed staff had one-to-one supervision every two to four months. Staff had not yet received an annual appraisal, but this was because the current provider had been operating the service for less than a year and the registered manager told us the appraisals were due within the next few months. There was a comprehensive programme of training and staff had opportunities to become qualified as trainers in specific areas. Staff fed back positively about this. The training programme was flexible and included courses about specific needs or health conditions people currently using the service had. A representative of a healthcare provider told us the service worked well with them and that the provider had arranged for staff to receive training to enable them to meet people's healthcare needs in line with best practice. New staff received a thorough induction that was designed to ensure staff knew how to keep people safe and care for them in ways that respected their rights. They were required to shadow and work alongside experienced staff to help them learn good practice. All staff including domestic staff had this induction programme, which was based on peer-reviewed research and current best practice guidance. This helped to ensure staff provided effective care to people.

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. We checked whether the service was working within the principles of the MCA.

Staff asked people for their consent before providing care. If a person who had capacity declined to receive care and support, staff recorded this and respected people's wishes. For example, care plans contained information about how to support people who declined help with personal care while respecting their right to refuse. One person was assessed as needing input from a health professional but sometimes declined to see them. This had happened recently when staff suspected the person's condition was relapsing and contacted the healthcare service. When the person declined, staff spoke with the professional instead and arranged for a review of the person's needs. For people who did not have the capacity to make their own decisions, staff were aware of the processes they need to follow in line with the MCA to ensure decisions made on people's behalf were in their best interests.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Several people living at the home had DoLS authorisations and the registered manager had a system to keep track of their expiry dates. Although some authorisations had expired, the registered manager showed us evidence that they had contacted the relevant authorities to request renewal before the expiry date and were waiting for them to do so.

Good

Is the service caring?

Our findings

People, staff and external professionals told us staff were friendly and caring. We observed staff interacting with people throughout our inspection. Staff were respectful and supportive in their approach and addressed people using their preferred names. They took time to chat with people about their interests and they created a warm and homely atmosphere by singing and making people laugh. We saw and heard evidence staff had taken the time to develop positive caring relationships with people and continued to do so. For example, we heard one member of staff asking a person about their favourite music. Another person's care plan contained information about how staff should approach the person to establish rapport with them, make them feel comfortable and gain their trust.

Where people required emotional support, staff took the time to listen and respond appropriately. We saw staff comforting people when they needed it. We observed one person telling a member of staff about something that had upset them and the member of staff sympathised. When they had finished talking, the member of staff cheered the person up by joking light-heartedly with them and singing a song together. The person said, "I'm not used to having people look after me like this [when living elsewhere]." Care plans also contained information to help staff understand why people might experience negative emotions and how to support them, particularly in the case of a person who was upset about losing some of their independence due to changing needs.

Staff understood the need for people to understand the choices they could make about their care. There was a handbook in bedrooms with information about the service. The registered manager told us they could print this information in different formats such as large print or simplified language. Care plans contained information about how people communicated, how staff should ensure people understood what they were saying and how to communicate with each person in ways that made them feel valued. We heard a member of staff discussing a person's choices about their routine with them, including when they liked to get up, how they liked to have their tea and what brands of toiletries they preferred. Care records showed staff gave people information about what choices they could make, for example what they could choose for breakfast, and recorded people's responses. This also helped staff get to know people better by learning about their preferences.

Staff understood the need to respect people's privacy and dignity. We observed staff erecting a privacy screen around one person while carrying out clinical procedures and supporting them to take medicines. The home used an electronic system for all care records. This was password protected and helped ensure people's privacy was respected in terms of personal information. Staff used clothing protectors to protect people's dignity at mealtimes and were discreet when offering support to use the toilet. People were dressed in weather appropriate, well-kempt clothing. Relatives told us they were "made to feel welcome at any time" and we observed staff greeting visitors warmly.

Staff supported people in ways that helped promote their independence. We observed staff offering people verbal support and encouragement as they used equipment to stand and move around the home. On one occasion, a senior member of staff was discussing with a person how they could be more involved in

managing their medicines.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "They're fantastic here. It's the best place of its kind there is. I'm going to my club tomorrow for Christmas dinner." One person's relative told us, "Staff will do anything for you."

We found the quality of care plans varied from person to person in terms of how responsive they were to people's individual needs. This was sometimes because it can be difficult to obtain detailed personalised information about people who are not able to communicate their views. However, in some cases, important information was missing from care plans. For example, two people were diagnosed with a serious mental health condition but their care plans lacked any detail about how this affected the person in terms of signs and symptoms, what might trigger a relapse or how staff could recognise the signs of this. We asked staff about this and they were able to tell us about the signs and symptoms and what would trigger contact with relevant healthcare professionals. However, because this was not in the care plans, there was a risk that staff who were not so familiar with these people might not be aware of what support they needed and when.

There was information in people's care plans about their preferences and how they liked their care to be delivered. This included preferred foods, daily routine and how people preferred to be supported with personal care. People were involved in planning their care. We observed a member of staff discussing a person's care needs and preferences with them. This included health needs, diet and how to tell if they were becoming unwell. The person said they needed toothpaste and a member of staff bought some for them the same morning. The home used an electronic care planning system and staff used portable technology that allowed them to check care plans and enter records without having to leave communal areas to get paper files. Staff told us this helped them spend more time with people and also helped ensure good communication as the system alerted them to any changes to care plans.

We received mixed feedback about the provision of activities. Although people told us about a recent Christmas party and an enjoyable visit from local school children, people also said, "There could be more to do" and, "It gets boring, sitting here." A healthcare professional we spoke with also felt stimulation and activities were sometimes limited. The home had two activities coordinators who arranged a number of activities and we saw several group and individual activities taking place including bingo and films, but people felt there was not much variety in the activities programme and that activities did not cater for individual interests and tastes. During our inspection the staff team engaged people in a "Sanderstead Bake Off" activity where people were involved in baking biscuits. Staff told us people really enjoyed this activity and we observed the atmosphere was cheerful and chatty. Photographs were on display of a "1950s Rock and Roll Party" the home had held.

Some people preferred or needed to stay in their bedrooms rather than spend time in communal areas. These people had care plans to inform staff about what activities suited them and how to protect them from social isolation. For one person, this included regular time with a religious leader who came to visit. For another person who was initially reluctant to leave their room, the service had worked with them to gradually overcome their reticence and engage with activities they were interested in, including working towards starting to attend church again. People and external professionals confirmed other people at the

home had their cultural and religious needs met.

Staff spoke with people and their relatives about the care people wished to receive at the end of their lives. This included where they wished to be at this time, who staff should contact, religious needs and funeral arrangements. People had end-of-life care plans with these details in. Although some of the end-of-life care plans did not contain personalised information about people's needs and preferences, the registered manager told us this was an area they were currently working on and were seeking guidance from appropriate sources, including plans to arrange training for staff with a local hospice. We will check this at our next inspection.

Relatives told us, "complaints and concerns can be aired" at relatives' and residents' meetings or informally with the registered manager. People also told us they were able to raise concerns if they needed to, although one person said, "I mention it, but nothing changes." On several occasions we observed people telling staff about minor concerns or changes they wanted made and staff responded immediately. One person told us, "I need more encouragement and opportunity on a daily basis." We later saw that person sitting with a senior member of staff to talk about their concerns. The member of staff listened sympathetically and wrote down the person's requests, apologised to them and told them what they would do to resolve the concerns. The member of staff later returned to the person to recap what their requests were and update them about what they were doing to meet them. The person smiled and said, "It's nice to know that you and [registered manager] are on my side!" The service had a clear policy and procedure for formal complaints and the registered manager showed us a new system they had set up to ensure they adhered to this when they received complaints. Records showed the manager investigated complaints appropriately, took action within the timescales specified by the policy and kept complainants informed about what was happening and what they should do if they were not satisfied with the response.

Requires Improvement

Is the service well-led?

Our findings

One person told us, "They run a good place here. It's always welcoming and I feel settled." Another person said, "The new manager has done wonders" and a third told us the registered manager was "making improvements all round." A relative told us, "The new management has made a difference." Staff and external professionals felt the manager was approachable and well organised.

We found the registered manager was not always sending us the notifications that the law requires them to submit. These include notification of abuse or allegation of abuse and notification of when the service successfully applies to deprive a person of their liberty under DoLS. We found records showing at least one allegation of abuse had been made about the service in November 2018 but we did not receive a notification. One person's care plan stated that the person sometimes made allegations that staff abused them, but we did not receive notifications about these allegations either. We also found several people had DoLS authorisations as part of the care provided by the service, but we had not received any notifications of these. This meant there was a risk of us not having access to information we need to check people are safe and receiving appropriate care.

Failure to submit statutory notifications is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We discussed this with the registered manager who told us they would make sure they sent the notifications in future. Since the inspection, the provider has submitted notifications to us. However, the provider remains in breach of this regulation because they need to demonstrate compliance with this regulation over a period of time.

The registered manager used a number of audits to check the quality and safety of the service. This included audits of call bells, medicines management and bedroom safety and cleanliness. When the audits identified problems, the manager made sure they were rectified by the time of the next audit, for example by arranging extra training for staff and updating care plans. The provider carried out a mock inspection in November 2018, which looked at the key questions we answered in this report. The mock inspection examined the quality of care including whether staff treated people with respect and paid attention to equality and diversity. We noted the provider had identified several of the same issues we found at our inspection, including some information missing from risk assessments and people waiting a long time at dining tables to receive their meals. The registered manager told us about their plans to improve the service, including the environment, which was also an area we identified for improvement. This showed the provider's systems were effective in identifying problems, but because the mock inspection occurred only three weeks before our inspection we could not be sure how effective they were at rectifying problems and improving service quality. We will check this at our next inspection.

We observed the registered manager speaking with people during the inspection. It was clear they knew people well and people appeared to enjoy talking to the manager. People and relatives knew who the manager was. The service had clear lines of accountability and staff knew whom they should report to.

There were clinical support workers who were trained to support the qualified nurses by performing some clinical tasks. Staff told us this also provided them with opportunities for professional development.

The home had meetings for residents and relatives to attend so they could share their views about the service and discuss any changes they wanted to make. A relative told us, "Family meetings every few months are good to give feedback. We always go, and issues and concerns can be raised and listened to." At the previous meeting in September 2018 people had shared ideas about activities they would like to do. People told us the manager listened to them and responded to their suggestions. The provider had carried out a survey to gather the views of people and their relatives in summer 2018 and again in October. Feedback was mostly positive although relatives fed back that they would like to be more involved in care planning. At our inspection we found evidence that people and their relatives were being involved.

Staff had the opportunity to attend regular meetings, including special meetings for night staff and clinical staff. The registered manager used these as a way of monitoring the culture of the staff team and to give staff opportunities to feed back about their work. They also carried out a staff survey in autumn 2018 where staff had the opportunity to share their views about the service. Staff felt the service was very caring and fed back positively about the registered manager and how the service had improved in the last few months. Staff we spoke with also felt the quality of the service had improved. We found evidence that where staff had identified areas for improvement in previous staff surveys the registered manager had picked these up and addressed them at staff meetings. The registered manager told us about challenges within the culture of the staff team that had arisen when the service transferred to the current provider and how they had overcome the challenges with a consistent, fair and positive approach to team building.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Registration Regulations 2009 Notification of other incidents The registered person did not always notify CQC without delay of the outcome of any request to deprive a person of their liberty, or of any abuse or allegation of abuse in relation to a service user. Regulation 18(1)(4)(a)(b)(c)(d)(2)(e)

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way. This included assessing risks to the health and safety of service users, doing all that was practicable to mitigate such risks and ensuring the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)