Methodist Homes

Torrwood 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?	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

Torrwood Care Centre ("Torrwood") is a residential care home providing personal and nursing care to 76 people aged 65 and over at the time of the inspection. The service can support up to 82 people.

Torrwood accommodates people across three separate units, each of which has separate adapted facilities. Two of the units specialise in providing care to people living with dementia.

People's experience of using this service and what we found

People told us they were supported by staff who were caring. People told us staff protected their dignity, independence and treated them with respect.

Torrwood had not been able to maintain the quality of the service since the last inspection. We found people's records lacked some essential detail. Records were not always complete and from initial assessment to writing the full care plan, details of people's past and present lives were not used to inform their current care and records.

All risks associated with people's needs had not been identified and/or records had not been updated to include the up to date details.

We have recommended the provider reviews their initial assessment recording to ensure people's needs are fully assessed and personalised and, the provider review their recording of people's health events and health professional's involvement to ensure they are complete and contemporaneous.

The Mental Capacity Act 2005 was not always applied correctly. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service used signage on important rooms to help people living with dementia identify them. For example, bathrooms and toilets. The décor of the service did not aid moving around independently. We have recommended the provider consult with a dementia specialist to gain advice on the décor.

People were not protected by good infection control practices. Staff were confused as to whose role different cleaning tasks were. This meant people's environment and health were being put at risk.

People, relatives and staff were supportive of the management of the service. Systems were in place to review the quality of the service. However, we found these had not identified the issues found on inspection.

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

Rating at last inspection
The last rating for this service was Good (published 11 March 2017). Safe however, was rated as Requires improvement. This was due to concerns raised about staffing levels about which we gave a recommendation for the provider. Staffing levels were not a concern on this inspection.

Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, responsive and well-led sections of the full report.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.

Enforcement

We have identified breaches in relation to how the service ensured good infection control, people's capacity to consent to their care, people's records were incomplete and ensuring the quality of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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?

Good

The service was 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.

Torrwood Care Centre

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 was completed by one inspector, one assistant inspector, a specialist nurse 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

Torrwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 inspection

We reviewed information we had received about the service since the last inspection. 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 used all this information to plan our inspection.

During the inspection

We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, deputy manager, nurses, senior care workers, care workers, housekeeper, maintenance person and the chef. We observed people's care to help us understand the experience of those who could not talk with us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment. We also looked at staff training, appraisal and supervision. A variety of records relating to the management of the service, including policies and procedures and maintenance were reviewed. We sought advice from the fire service to clarify our observations.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

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 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.

Preventing and controlling infection
• People were not assured to be protected from cross contamination.
• On the first day of the inspection there were adverse urine smells in the service which improved on the second day. Once alerted by the inspector, the carpets were cleaned, and no odours persisted.
• The communal sinks and toilets, kitchenette areas on each unit and one of the treatment rooms were not kept to an acceptable standard of cleanliness. Faeces was seen on the grab bar of one of the toilets. The sinks and toilet rooms had not been cleaned properly for some time with grime and collected dust visible. The kitchenette areas where staff prepared toast and cereal for people's breakfast were also dirty. Tea/coffee was splashed down the units and crumbs/old food evident. The sinks and draining boards had also not been kept clean.
• Cleaning cloths on the units were being used by care staff multiple times to clean a food preparation area and in one of the treatment rooms. Along with the dirty cloths there was no available COSHH approved cleaning product available. Care staff were telling us the cleaning was the responsibility of the cleaning staff and cleaning staff the other way around.
• On one unit, people's tables that sat by their chair had not been cleaned.
• In the laundry room, dirty washing coming down the chute fell onto the floor in red canvas bags. This was posing a risk of infection going on to the floor and staff. The service ordered containers to stop this happening in the future.

Assessing risk, safety monitoring and management
• People at risk of choking were not risk assessed. People's records did not always detail who had been consulted to give advice or if concerns had been followed up on. For example, one person was noted as struggling to swallow their drink in July 2019, but no further action had been taken to assess this. Following the inspection, the registered manager advised, the assessment for this person has now been completed.
• People at risk of malnutrition had risk assessments in place however, it was not clear in their records what help, or support had been gained in respect of this. For example, a person had lost weight. Their weight had continued to be monitored and a fortified diet offered, but they remained underweight. There was no record the person had been referred to a dietician or other health professional.
• One person had an alteration made to their room which had not been risk assessed in respect of all associated risks including those associated with fire. This has been shared with the fire service who gave us advice during the inspection. The alteration was removed when highlighted.
• In some people's records, what had been written about them was not current or had been added to over

several reviews. The picture was then confusing as to what their current need was. For example, a person was noted in their mobility care plan as having a Zimmer frame requiring two staff to support them however, later in their record it stated a hoist was required to reduce their risk of falls. This could mean staff who did not know people well offered the wrong support.
• One person at very high risk of falling, and who had multiple falls recorded, had not been reviewed to ensure their footwear was safe. We observed their footwear to be in a poor state of repair and spoke to the registered manager. We were told the family were responsible for this, but action had not been taken to ensure this was resolved for the person. Following the inspection, the registered manager advised the person had been referred to the falls clinic and the footwear replaced by the family.
• Bottles of washing up liquid were easily accessible to service users living with dementia and a risk of consumption. The registered manager was advised of these bottles and then asked staff to remove them.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A range of other risk assessments such as reviewing people's risk of falls, skin damage and when being supported to move by staff were in place and reviewed monthly.
• People told us they felt safe in staff's care; they felt staff understood their needs and kept them safe from coming to physical harm.
• Personal emergency evacuation plans were in place to support people to leave the building safely in an emergency. A clear contingency plan was in place to support this process.
• Equipment was checked to ensure it was well-maintained.

Systems and processes to safeguard people from the risk of abuse
• People and their families told us they felt safe at the service and would talk to the unit leads and/or the registered manager if they were concerned. Everyone expressed they felt listened to and action would be taken if it were needed.
• A relative said, "I would always approach a nurse in the first instance. I feel (they) know my mother."
• Staff knew the systems and processes to raise safeguarding and whistle blowing concerns. Staff felt action would be taken should this be required.
• People said, – "Yes I feel safe. It's just being here; them looking after you" and, "Yes. I let them know what I require and then they do it. I always feel safe."
• A relative said, "Safe here? Absolutely. No concerns, whatsoever."

Staffing and recruitment
• People, family and staff were happy that there were enough staff to meet their care needs and spend time with them.
• Occasionally, people told us they noticed there were less staff on some days, but they did not feel this adversely affected them. Staff also said this could be an issue and reduced the time they had to spend with people. Staff however, worked together to ensure people's needs were met.
• Volunteers were used by the service to support areas of people's life at the service.
• Staff and volunteers were recruited safely. Staff were employed in sufficient numbers to keep people safe.
• The provider and registered manager ensured people's current needs were reflected on when judging how many staff were to be available.

• When the service needed to bring in other staff, they tried to use agency staff who had been before to ensure continuity.

Using medicines safely

• People's medicines were ordered, administered and disposed of safely. People had regular GP oversight of their medicines to ensure their needs were being met.
• Only trained staff administered medicines.
• People's medicines were accurately recorded in medicine administration records (MARs).
• People's topical creams were accounted for and staff had body maps to reflect on to ensure they were applying them correctly.
• In one unit, people's records did not clearly say what people's current medicines were or what cream staff were to use on people's skin. We have advised the registered manager of this so improvements can be made.
• Medicines that required higher level controls were safely stored. Each medicine was accurately administered and recorded in the MARs and dedicated book and witnessed by two staff.

Learning lessons when things go wrong
• Systems were in place to reflect on errors and complaints.
• Staff were involved in this process through staff meetings, for example.

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 Good. At this inspection this key question has deteriorated to Requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA was not always applied correctly. People who were assessed as having capacity to consent to their care and treatment and reside at the service had DoLS applications made for them though they had capacity. In feedback, we were advised this was because the MCA assessment had not been updated in line with the person's changing need.
• The service had sought the consent of, and consulted with, the family members of one person in respect of their diet, with or without Lasting Power of Attorney, without first establishing that the person lacked capacity. A best interests decision had not then been recorded and the full range of professionals responsible for the person's care, involved in that decision.
• This meant people's human rights may not then be fully respected and protected.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Best interests decisions were clearly recorded for people who required their medicines administered without their consent and, for the use of bed rails and some other specialised equipment.
• The PIR stated, "Risks are assessed and depending on the Mental Capacity of the resident, they can either make their own decision or a decision can be taken in their Best Interest. e.g. a resident with early dementia felt they were capable of walking into town and back. Their ability was assessed, and a risk assessment was done, and (they) currently walks into town and returns."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People had initial assessments in place. The initial assessments lacked a lot of personalised detail that could be used to plan people's care going forward. The registered manager advised this was sometimes down to the lack of available data if the admission was from hospital.
• The initial assessment often held basic details gathered about people. For example, one person's assessment included "two sons", job title, "fishing", deal with change "fine" written across the available boxes. No further detail was added about how this was important to the person and, how as a service they were going to meet this or ensure staff knew what was important to them.
• The 2017 NHS England Dementia: Good Care Planning. Information for primary care providers and commissioners page 9 states, "The preliminary care planning conversation with the person living with dementia (and their carer if appropriate) should begin with asking what is important to them, with an initial focus on what their main concerns and priorities are regarding the present time and the future outcomes". This was not reflected in the care planning at this service.

We recommend the provider reviews their initial assessment recording to ensure people's needs are fully assessed and the care delivered to meet these needs is personalised.

• The PIR advised, the provider's quality team provided information and updates on national developments and, "Somerset CCG have regular forums for Care Homes to attend to keep them up to date with clinical and government policy changes."

Supporting people to live healthier lives, access healthcare services and support
• The service worked closely with local GPs to ensure consistency of healthcare.
• Staff had training in oral care and people had regular dental appointments.
• People had appointments with the optician and for foot care as desired.
• People living with certain health conditions had reviews as needed. For example, a person living with diabetes had this reviewed by their GP, nurse, podiatrist and optician.
• A person told us, "I have seen the GP this morning. There're two nurses here and a couple of times they have called the night doctor out. Teeth, I organise myself, no problem. Sight – they are going to organise for me. Someone comes in. My family take me, or they take me in the mini bus."
• A relative said, "[My relative] saw the doctor yesterday after my sister raised concerns. I have total confidence in them here."
• We found people's records, where staff record people's health issues and health professional involvement, were not always clear. Staff were using different sheets of paper to record individual events. This made any event record difficult to follow through to its conclusion.
• The staff were acting quickly to review and ensure people's skin did not breakdown. When concerns were noted there was an excellent initial assessment and for one person, clear progress recorded. However, this was not the same for everyone.

We recommend the provider review their recording of people's health events and health professional's involvement to ensure they are complete and contemporaneous.

Adapting service, design, decoration to meet people's needs
• The service was a purpose-built care home able to accommodate people with varying levels of mobility.
• Signs in line with dementia care good practice were used to identify significant rooms such as bathrooms and toilets for people.
• Moving around the home had not been considered from the perspective of someone living with dementia. The corridors and carpeting for example, did not give definition and other signage was not in use to help this.

We recommend the provider consult with a dementia specialist to gain advice on the décor.

Staff support: induction, training, skills and experience
• Staff were trained to understand people's needs except in Parkinson's Disease, which was raised with us by a person living with this condition. The registered manager advised the nurses had the training on this health issue but not the care staff.
• Staff said they could suggest additional training and were supported to stay up to date with current guidance.
• New staff underwent an induction that included training, shadowing and review. The PIR states, "New staff follow a documented and comprehensive induction programme and complete mandatory training. New staff are super numeracy for initial two weeks." A newer member of staff confirmed this was their experience.

• For staff new to care the PIR stated the Care Certificate will be given. The Care Certificate is a nationally agreed standard of training for staff new to care.
• Staff had regular individual supervision, appraisal and checks of their competency. The registered manager advised they used the supervision sessions to discuss support and to go over essential topics such as Sepsis. This was to ensure staff understood the issues and improved their practice.
• Staff felt supported to ask questions and would be supported to learn if they did not understand something about a person or their condition. One staff member said, "I would speak to my nurse and they're all very helpful. There is always someone to talk to."

Supporting people to eat and drink enough to maintain a balanced diet
• The majority of people we spoke with were happy about the food and that it met with their preferences. Everyone added that the service was flexible and catered for differences in taste and culture.
• Special diets were catered for. People with food intolerances and allergies had their needs met with their food prepared separately or first. A person told us, "The food in here is excellent. I have a wonderful appetite. I am on a special diet. I like custard and cake for afters."
• In the areas of the service where people living with dementia lived, people were offered the choice at the table of two plates, so they could visually see the food. On the nursing unit, people were asked what they would like the day before but could change their mind.
• The dining rooms were presented nicely with table cloths, condiments and menus. We observed staff supported people to eat as needed and were engaged with people living with dementia to keep them involved with eating their meals.
• The registered manager advised that where there were concerns about people's eating and drinking, people had this need tracked for 72 hours after which time staff included the details in the daily records. We viewed these records, however there was no total or evidence to show these were reviewed to ensure people were eating and drinking enough. It would have also been an onerous task to go through these records to have a complete picture of people's eating and drinking needs. The registered manager further advised that should a concern be raised, the deputy manager and they would go through these records to prepare a report as required.

Good

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 remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us, "Everybody here is very sweet, and there is nobody I don't like" and, "They are all nice people. Nothing nasty."
• People were supported to access the community and maintain their faith and culture.
• Volunteers acted as befrienders for people who would benefit from someone to talk to.
• A music therapist was also employed to support people emotionally.
• People said their relatives could visit freely and were always welcomed. People could go to their room or any of the lounges to spend time with their family and friends.
• People told us they had the opportunity to make friends in the service. One person said, "We meet each other, talk to each other."

Supporting people to express their views and be involved in making decisions about their care
• People felt staff listened to them. For example, People said they were asked which gender of carer they wanted supporting them and this was respected. A person said, "They are very kind and very patient. I don't mind a bit [having a male carer]. They are really very good." Another person said, "The staff are here to listen to you. They are very kind to me and I think they are kind to everybody."
• People said they could go to sleep and rise when they wanted.
• People had a choice of having a shower and/or bath and staff were flexible in meeting that need. A person said, "I have a shower every week. I would imagine so [have a shower at another time]. I can choose when to go to bed and when to get up."
• People, regardless of their cognitive ability, were supported to make choices about their day. For example, what to do, what to wear and how to keep active.

Respecting and promoting people's privacy, dignity and independence
• People told us that staff respected their privacy and treated them with dignity and respect.
• People said, "When I am awake, they do [knock on my door]. They pop in and see I am okay. They shout my name, knock on the door and come in. I don't feel I have been invaded" and, "They always knock on the door. Everyone is known here by their first name."
• People were supported to remain independent for as long as they could. People living with dementia were able to walk around the service and into the garden. A person said, "I can put myself to bed. I usually wait until the nurse comes with the medication. I can get out of bed and somebody gets me dressed and washed.

They usually ask me in the morning would I like some help getting ready. They always apologise when it's intimate."

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 Good. At this inspection this key question has deteriorated to Requires improvement.

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

• People said, "I am aware that [my care plan] exists. Whether it's ever revised or changed, I don't know. If I wanted to see it, I could. My daughter does get involved" and, "I think they know what I need. I have asked them. My daughter would see to it if I said something."

• Care plans were in place that detailed the clinical areas important for staff to know about people. For example, medical conditions and clinical tasks. These were reviewed and updated as required. There was good follow on records of specific tasks such as when a person needed and had their catheter bag changed.

• There was also good evidence of communication with relatives.

• The care plans however, lacked personalisation, and the records of how people's day had been, lacked any personal detail of how that person had enjoyed, or not, their day. The daily records were a list of tasks completed or stated, "all personal care given".

• The care planning for people living with dementia, lacked the specifics that are recommended in the NHS England (2017) care planning for people living with dementia. That is, the care plan should be "personalised, unique to the individual and owned by them". It should be written in dementia friendly language and, should include specific goals and actions for how people and the service will manage their health, wellbeing and the support available. This meant people's care planning was not being centred on them.

• Some staff we observed responded well and quickly to people. However, there were two incidences where staff did not respond speedily to two people living with dementia, and prioritised tasks rather than the needs of these people. One person was vocalising a concern about how they felt, and another wanted to go out in the garden. Staff told us these people always behaved in this way but did not engage with either person to alleviate their situation.

• When the first person, as mentioned above, stated to the inspector that they had a pain in their leg, the staff responded quickly to see if they wanted to have their 'as required' pain relief medicine. However, no monitoring tools were in use by staff to help gauge mood and pain.

• When we spoke with staff, they demonstrated they knew people well. Staff said they had detailed handovers between shifts and felt they knew how each person was. This level of detail and knowledge was not then evident in people's records. This meant new staff or temporary staff would not have this information available.

• Some records held details about people's past, but these were not then used to personalise what was written about people.

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.

• We did not observe staff using other forms of communication other than the spoken word. Staff supported people living with dementia to choose their food and drink by showing them the plates or containers.
• The PIR stated that people's communication needs were addressed on a person by person basis. People can write their choice and staff have been trained to describe objects to people with reduced or no ability to see. The PIR added, "In the event of a specific concern we would approach external support for specialist advice. For example, sign language support, audiology, opticians, Parkinson's nurse, dementia wellbeing.".
• People's records lacked personalised details of how people communicated, or guidance for staff on how to achieve good communication with the person.

Not ensuring people's records were complete is a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) 2014.

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
• The service employed an activity co-ordinator, a volunteer co-ordinator and a music therapist. These staff and the volunteers undertook the same training as care and nursing staff. This included training in meeting the needs of people living with dementia.
• People were given a list of the activities available and encouraged to take part. People could have time on a one to one basis if they preferred.
• People told us, and we observed, they attended a range of activities. People said, "I meet people. I love my wireless. I can't see the TV. I like quizzes and music. Football. I love rugby, but my main sport is football. I love sport"; "I like; watching TV if there's something on. I love music from being a child. Exercise classes" and, "One of the [activity] people who comes in to organise will ask 'are you going to this or that' and remind you it's on."
• The service linked with community groups. A parent and toddler group took place once a month with people living at the service attending as well. The intergenerational approach was used to support people talk about their past and, added to the lives of people and the visiting parents and children. Staff added, "One parent brings their guitar. The residents reminisce about their childhood and children. One resident talked about when she brought up her children and ran a bakery."
• School children from two local schools came into the service to play instruments and spend time with people. They were encouraged to understand what it is like to live with dementia and carry that learning into the community and life. The music therapist advised, "I did a lecture at the school about music therapy and dementia. I was trying to promote music therapy and raising awareness about dementia."
• The service opened their doors to the community, for example, they were soon going to be enabling a person with early onset dementia who lived in the local community to come and work with the chef.
• Music therapy took place with individuals and on a small group basis with people. The main reasons for referral were anxiety, agitation and loss of cognitive ability. The therapist stated, "I try and monitor what that is" and, "What's also great is when family members come in and they can see the lift in people's moods too. It means they can see another side to their parent."

Improving care quality in response to complaints or concerns
• The provider had a complaints system in place. The registered manager investigated complaints.
• Staff discussed the outcomes in staff meetings to share learning from these.
• People said they would raise a concern or complaint if necessary. One person said, "I would think any

number of staff would be equally approachable."
• A relative said, "All the boxes are ticked. I have not a single criticism of this place. I have seen nothing but care, consideration and a smile."

End of life care and support
• People were encouraged to think about their end of life requirements in advance.
• Medicines to relieve pain were sought to enable people to have a pain free death if this was needed.
• Family could stay at the service to be with their relative at their end of life.
• We saw compliments from family of people who had passed away. These complimented the staff for looking after the person and their family well. One family wrote, "I was really impressed by the professionalism and attention shown".

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 Good. At this inspection this key question has deteriorated to Requires improvement.

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
• There was a wide-ranging auditing system in place. Completed by the registered manager and provider. However, these did not identify the issues we found on inspection and therefore the quality of the service had not been maintained.
• During this inspection we found systems were not operating effectively in respect of ensuring good infection control, that the MCA was being fully met, that all risks were assessed and, people's records were complete and contemporaneous.
• Most staff were clear about their roles. There was however, confusion among staff around who was responsible for which cleaning role. This impacted on the environment for people and became part of the concerns expressed in respect of infection control.

This is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Daily senior management meetings took place to ensure the day by day needs were being met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People, family and staff felt they could approach the registered manager and deputy manager.
• People commented that they saw the deputy manager more. One person said, "I don't know who the [registered] manager is here. I know [the deputy manager]. I would feel able to talk to her. I could talk to her, but I don't see her every day, but I could ask for her." Another person described the deputy manager as someone "who gets things done."
• A relative said, "[The registered manager] is brilliant, she's always around. [We have] No complaints."
• Staff felt there was good team working with excellent support between them. One staff member said, "The management team are very professional."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relative and residents' meetings took place. So far in 2019, there had been two.

• The PIR stated, "The Home has a Quality Circle, and this will continue. Membership includes staff, residents, families and volunteers. Topics are chosen by them and include how food and beverages are presented to residents who wish to stay in their rooms, purchasing a better shroud, trips out, film days, obtaining iPad (tablet computers) for residents."
• Staff had meetings where they could express their views. Staff felt they could put forward new ideas to improve the service. Yearly appraisals and supervisions could also be used for this.
• The local community were encouraged to attend open days and Fetes which the PIR described as being "well attended".

Continuous learning and improving care; Working in partnership with others
• Senior staff attended local dementia care forums.
• The Somerset CCG Nursing Home Support Team were asked to support them as needed.
• The PIR stated, the provider was "currently supporting all of their Managers to attend a four day Engaging Leadership programme." In order to develop their staff to achieve the best they can be in delivering a great service."

How the provider understands and acts on the duty of candour (DoC), which is their legal responsibility to be open and honest with people when something goes wrong.
• The provider had policies and practices in place to ensure they adhered to the DoC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 11(1)(2)(3) Care and treatment was not always in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12(1)(2)(a)(b)(h) Care and treatment of people was not assured to always be safe due to not assessing all risks to the health and safety of people and doing all that was reasonably practical to mitigate that risk and, ensuring good infection control practices were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17(1)(2)(a)(b)(c) Systems and processes were not operating effectively to ensure the quality of the service; assess, monitor and mitigate all risks and ensure accurate, complete and contemporaneous records of people's care.