Windsor Court Care Limited

Windsor Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 30 and 31 July and 6 August 2018. The first day was unannounced.

Windsor Court 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. Windsor Court does not provide nursing care. The home is registered to accommodate a maximum of 48 people who require support with personal care. There were 27 people living in the home at the time of our inspection.

Windsor Court was registered with a new provider in May 2017 and this was therefore the first inspection of the service since this took place.

Accommodation is provided in individual bedrooms on the ground, first and second floors. Some rooms have ensuite facilities. There is a lounge and a dining room on the ground floor and two further lounges on the lower ground floor. Following the purchase of the home by the new registered provider in 2017, a comprehensive refurbishment programme had been started. This involved some major building and structural works, the addition of a new through floor passenger lift and redecoration. At the time of the inspection the building works had been paused to allow people living in the home, and staff, a break from the disruption. The registered manager advised that the completion of the works was planned but that the total number of people living in the home was at the maximum until the work was completed.

The service was led by a registered manager. 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.

People said they were happy living at Windsor Court and they felt safe and well cared for. They also told us their care and support needs were met and that the staff were kind, caring and respectful. Staff spoke knowledgeably about people's needs and how to support them. People were treated with dignity, respect and kindness. Their independence was promoted. However, we identified that there were a number of issues which needed to be addressed.

The building was part way through a major refurbishment but work had been halted temporarily at the time of our inspection. Work started within some areas of the home had not been fully completed. We found that some areas of the building were not clean and that infection control standards had not always been maintained.

The administration of prescribed topical medicines was not always fully effective. Some items were not stored securely, appropriately named and labelled and opening dates were not always recorded This meant

that some people may not be receiving their prescribed medicines correctly especially where items may become less effective after being open for a period of time.

A new computerised care records system had been introduced and not all of the required information was being recorded because staff had not found ways to do this. For example, there was no record of total fluid intake per day and no care plans for specific conditions such as Parkinson's disease or diabetes. The home also had six interim care beds for people who were medically fit to leave hospital but not yet able to return home. Assessments and care plans were not in place and ready for people's admission to the home and in some cases, records were not in place a number of days after their admission. This meant that staff may not have the information they needed to fully support people.

Governance systems and audits were in place to monitor quality of work which included infection prevention and control, risk assessments and medication compliance. However, these had not identified the shortfalls we found at this inspection.

The care records for one person contained conflicting information which meant that it was not clear what the person'sneeds were and how these were to be met. Again, audits of care plans had not identified this..

People were protected from abuse and neglect. Staff knew how to raise concerns about poor practice and suspected wrongdoing under the provider's whistleblowing procedures.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005, including the deprivation of liberty safeguards. Where people could give consent to aspects of their care, staff sought this before providing assistance. If there were concerns that people would not be able to consent to their care, staff assessed their mental capacity. Where they were found to lack mental capacity, a decision was made and recorded regarding the care to be provided in the person's best interests. Staff worked in line with the requirements of the Mental Capacity Act 2005. The registered manager understood the requirements of the Deprivation of Liberty Safeguards.

There were sufficient staff on duty to keep people safe and provide the care they needed. Staff had the training and supervision they needed to perform their roles effectively. Robust recruitment processes helped ensure that only suitable staff began working at the service. These
included obtaining references and a Disclosure and Barring Service (DBS) check before candidates started working with people.

Staff were positive about their roles and told us they were well supported by the registered provider and registered manager.

Further information is in the detailed findings below.

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.

Systems and procedures to keep the house clean and prevent and control the spread of infection were not always effective.

Some areas of medicines and risk management needed review to ensure that they were fully effective and met people's assessed needs.

People felt safe and there were enough staff to meet their needs.

Is the service effective?

Good

The service was effective.

Staff were supported through training and supervision to be confident and capable in their work.

Staff made timely referrals to healthcare professionals, and acted on their recommendations.

People told us that the food was good and they enjoyed the meals at the service.

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Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness. Their independence was promoted.

People, and where appropriate their relatives, were fully involved in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care and support needs were not always recorded and

planned for which meant that staff may not have the information they need to fully support people.

People and their relatives were confident that they were listened to if they had concerns and knew how to complain if they felt it was necessary.

Is the service well-led?

Requires Improvement

The service was well led but required further improvements.

People, relatives and staff had confidence in the management of the service.

Quality monitoring systems were not always effective and record keeping required improvement.

Windsor Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 30 and 31 July and 6 August 2018. The first day of the inspection was unannounced. An adult social care inspector carried out the inspection and was supported by an inspection manager on the second day of the inspection.

We used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed all the other information we held about the service, including previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also contacted the local authority commissioners of the service to establish their view of the service.

As part of the inspection we spoke with six people who lived at the home to find out about their experiences of the care and support they received. 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 spoke with nine staff members, the deputy manager and the registered manager. In addition, we spoke with three visitors to people living in the home, two district nurses and a student nurse.

We looked at seven people's care plans; these included risk assessments and medicine records. We also looked at records relating to the management of the service including audits, maintenance records, and five staff recruitment, training and supervision files.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe and well cared for. When we asked one person if they felt safe, they told us, "I'm really happy with everything here. I only came here for short break but would certainly consider living here full time if I needed to." Visitors told us they felt their loved ones were safe at the service. People looked relaxed with staff.

The building was part way through a major refurbishment, but work had been halted temporarily at the time of our inspection. Work started within some areas of the home had not been fully completed. For example, there was a piece of hardboard taped between the dining room and private dining room acting as a ramp, there was black and yellow hazard tape around areas in the corridor near the kitchen, and there were unfinished areas outside of the home at the front and rear including some areas that were uneven and potentially hazardous in particular, the area outside the lower ground floor lounge doors.

During a tour of the premises it was noted that some area of areas of the home had not been thoroughly cleaned. Baths and sinks were stained with limescale, the lift floor had marks and debris on it throughout the second day of the inspection, the dining room floor was dusty after lunch and not properly cleaned on the first and second days of the inspection, many floors needed vacuuming and equipment such as rotastands and a weighing scale chair were required cleaning. Woodwork and door handles were also stained in some areas. Procedures to prevent the spread of infections were not being followed. There was no separate hand wash area in the laundry. The floor behind the washing machine and tumble drier was dirty. The walls and floors in the laundry were not impermeable and could not be easily cleaned. The layout of the laundry area did not make a dirty to clean flow easy: dirty linen was left on the floor of the laundry on the first day. Throughout the inspection, laundry trollies containing soiled laundry were left around the home for long periods of time; this was both a potential hazard and also contributed to some malodours which were detected during the inspection. Following the inspection, the registered manager told us that they would identify more suitable areas for storage of the trollies and ensure staff collected soiled laundry more frequently.

Other malodours were detected in the main lounge on the ground floor and in some carpeted bedrooms. Also, from the toilet between the senior carer's office and the dining room. This was possibly contributed to by the offensive waste bin which was full most times it was checked throughout the inspection.

Wash bowls in people's rooms were left with standing water in them which can harbour bacteria. People's denture pots had not been cleaned thoroughly and were left with standing water in them.

Clean linen was being stored in bathrooms and on trollies in corridors. This means that there is potential that the linen could be contaminated. Bathrooms were also being used for storing other items such as mobility equipment.

Following feedback at the end of the inspection, the registered manager took immediate action to address these points and confirmed later by email that steps had been taken which included providing additional

staffing for cleaning duties, updating cleaning schedules, identifying other areas to be used for storage and making improvements to the laundry area.

The communal bathrooms on the lower ground floor, ground floor and first floor were visited during the first two days of the inspection were not ready for immediate use when they were seen. As mentioned above, they had been used as storage areas and in addition maintenance/building work had been started and not finished. For example, the boxing in of pipes had been removed leaving damaged and broken tiles and access to a dirty area, holes had been drilled in tiles or tiles in other areas damaged and not repaired or replaced.

Equipment owned or used by the registered provider, such as specialist beds and hoists, was suitably maintained. However, the chef reported difficulties in ensuring people's food remained hot during food service times because the heat lamps for food service were not working. They reassured us that they were able to keep food at a safe temperature but said this was not as easy as it could be. They told us that they had reported this before, but no action had been taken. Buttons in the lift for selecting the correct floor were not properly labelled. This meant that some people may not have been able to use the lift independently.

A fire risk assessment had been carried out in December 2017 that identified issues to be addressed. There was some evidence that these had been attended to, but discussions evidenced that the areas of the building that were in use or out of action at the time of that risk assessment were different to the areas that were in use at the time of the inspection. The fire risk assessment had not been fully updated following the changes to the building.

A contractor highlighted at a service visit in July 2018 that there were no emergency lights in six areas on the lower ground floor, two areas on the ground floor and two areas on the first floor. This had not previously been identified through other tests and checks that had been carried out and the fire risk assessment for the building had also not identified this issue. The registered manager confirmed that this work was being scheduled as a priority and later confirmed that work had been completed.

We raised our concerns with Dorset and Wiltshire Fire and Rescue Service who later visited the home and made recommendations. The registered manager later confirmed that they had taken action to address all of the issues raised.

Moving and handling practices needed to be reviewed to ensure privacy and dignity were maintained and best practice was followed. Many of the people living in the home needed two staff to support them safely, especially those people who required support when mobilising. Staff had completed training in this area but evidence their competency to support people safely had not been was not available at the inspection. The provider later stated that an assessment of competency was included with the training

Some people were unable to weight bear and required hoisting from bed to wheelchair and wheelchair to armchair in the lounges. We observed that one person was transferred to an armchair in the lounge and privacy screens were not used. We observed that, with the exception of some in-situ slings, there was mainly only one type of sling used which was also not dignified for use in a public area. Following the inspection, the registered provider told us, 'The use of an access sling to hoist a resident is a safe method that is used if a resident is awaiting an assessment or purchase of an in-situ sling'. During the inspection we provided advice to the registered manager about the support available from the local Occupational Therapy Department about the range of equipment available.

Some people needed help to reposition themselves in bed. Special equipment should be provided to ensure

that this is done safely. However, we were unable to find any such equipment in two people's rooms. Following the inspection, the registered provider advised that the equipment was being laundered.

The service had identified, through assessment tools and monitoring people's weight, that some people were at risk of becoming malnourished. Staff were aware of the people this related to and told us they encouraged people to eat and drink. Food and fluid monitoring charts had been put in place but these were not always completed properly: there were no target amounts of food or fluid that people should consume and therefore there was no measure in place to judge if people's intake was poor and action needed to be taken. The registered manager confirmed that this had previously taken place but had not transferred on to the new computerised records. They immediately implemented a system to ensure that peoples total food and fluid intake was assessed at least once in every 24 hour period and action taken if this was required.

Systems for the administration and management of medicines were not always fully effective. There were a number of prescribed topical creams in people's bedrooms or ensuite facilities that were not being stored securely. Some items can have a limited period of effectiveness once opened. , Some of the topical medicines that we checked did not have the date of opening recorded on them. Some items had been purchased separately because, although the person still needed them, they were no longer provided on an NHS prescription. These items had not been named or labelled in any way which meant there was a risk they could be used for other people and cross contamination could occur. The date these items were opened had also not been recorded. Analysis of the medicines training provided showed that only senior care staff completed this. However, all care staff were involved in applying prescribed creams for people during personal care. This meant that they were administering medicines without suitable training and assessment of their competency.

The registered manager confirmed that an audit of medicines in the home was completed once a month. This tool was not fully effective as it had not identified the issues above.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed and action had not always been taken to mitigate any such risks. People were not protected against the risks associated with the unsafe management and use of medicines. Systems and procedures to keep the house clean and prevent and control the spread of infection were not always robust.

We checked the storage and administration of medicines, and discussed medicines management with the registered manager. Records showed that medicines were recorded on receipt, when they were administered and when any were returned to the pharmacy or destroyed. Medicines administration records, (MAR), contained information about people's allergies and had a recent photograph of the person. MARs were complete and contained the required information where doses were not given.

Some people took medicines that required stricter controls by law. These medicines were being administered and stored safely. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored and within the acceptable range. The temperature of the room where medicines were stored was also monitored and was within the acceptable range.

At this inspection there were satisfactory systems in place to safeguard people from abuse. The staff we spoke with demonstrated a good understanding of safeguarding people: they could identify the types of

abuse as well as possible signs of abuse and knew how to report any concerns they may have. Records showed that the provider had notified the local authority and CQC of any safeguarding concerns or incidents and the registered manager had taken appropriate action when incidents had occurred to protect people and reduce the risk of repeated occurrences. Information about the outcomes of and learning from safeguarding investigations had been shared with staff. This meant staff had been made aware of the actions needed to minimise the risks and improve care and support to people.

Arrangements were in place to keep people safe in an emergency. Staff understood these and knew where to access the information. Each person had a personalised plan to evacuate them from the home and these were regularly reviewed. The home also had plans in place to manage interruptions to the power supply, breakdown of equipment or other emergencies.

Risks to people were assessed and managed in the least restrictive way possible. Risk assessments covered areas such as moving and handling, falls, malnutrition, risks of pressure sores developing and the use of bed rails. People's care plans took these into account. Risk assessments were reviewed monthly or sooner if people's needs changed. People were encouraged to take risks to maintain their independence as far as possible. For example, people who could walk were encouraged to do so rather than using wheelchairs even though this would increase their risk of falls.

Accidents and incidents were monitored to look at possible risks or failures in systems or equipment. Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary.

Following any accident, the registered manager reviewed the person and their records to make sure that any identified actions had been followed through. At the end of each month, all accidents and incidents that had occurred in that period were reviewed to look for any trend or hazard where action could be taken to reduce further such occurrences.

People living at the home, relatives and staff, all told us that they believed staffing levels were sufficient to meet people's needs. People said their call bell was answered in good time and their care and treatment needs met. Relatives also confirmed that they had observed that call bells were answered promptly and people were checked regularly where they were unable to use the call bell.

There were satisfactory systems in place to ensure that people were supported by staff with the appropriate experience and character. Recruitment records showed that the service had obtained proof of identity including a recent photograph, a satisfactory check from the Disclosure and Barring Service (previously known as a Criminal Records Bureau check) and evidence of suitable conduct in previous employment.

Good

Is the service effective?

Our findings

People told us staff were skilled and that they had confidence in them. Visitors and health professionals told us they found the staff approachable and understanding. A member of staff told us they had attended various training courses since beginning their employment at Windsor Court. They said the training had given them confidence they felt "well equipped to look after people."

Staff confirmed that they received the training they needed to carry out their roles. Training records showed that staff had received training in essential areas such as safeguarding adults, consent and mental capacity, infection prevention and control, moving and handling and fire prevention. New staff confirmed that they had undertaken a comprehensive induction which also provided them with the Care Certificate, as well as working some shadow shifts to enable them to observe and understand their role and the range of people's needs. The Care Certificate is a set of standards and skills people working in adult social care need to meet before they can safely work unsupervised.

Some staff had not completed refresher training within the timescales laid down by the registered provider. The registered manager demonstrated that they were aware which staff required refresher training and had training sessions planned to address this.

Staff were provided with support and supervision. Staff confirmed that supervision took place to enable them to discuss their work, resolve any concerns and plan for any future training they needed or were interested in undertaking. Supervision sessions were documented on staff files and there were clear processes in place to inform and support staff where issues or concerns were identified with their performance.

Staff had a good understanding of how people preferred to be cared for. During the inspection there were many examples of staff reassuring people if they became upset or chatting to them about their family or previous events in their life. Discussions with staff showed that they understood when people had the capacity to make decisions for themselves and that these decisions should be respected.

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 told us they made their own choices and that staff listened to and acted upon their decisions. Consent was sought by the service with people signing agreement to things such as the use of photography and equipment such as bed rails.

Where people lacked capacity to make specific decisions, mental capacity assessments and best interests decisions were in place. For example, there were assessments in place for the provision of personal care

and the use of pressure mats to alert staff when people were mobilising who may need support.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood when DoLS applications would be required and had a system in place to ensure they were aware when DoLS authorisations expired and any conditions had been adhered to. During the first day of the inspection we noted that one person had some specific conditions attached to the authorisation which were not recorded in their care plan. This meant there was a danger that the conditions would not be complied with. The registered manager took immediate steps to rectify this and remind staff to ensure all conditions were recorded in future.

People were supported to maintain a balanced diet and to have plenty to drink. People and relatives were positive about the food and told us they had a choice. The daily menu was available in the dining room. People who had difficulty remembering what was on the menu were shown plated meals at mealtimes to help them choose. Meals looked appetising. Cultural and health-related dietary needs and preferences were documented in people's care records, and food was provided accordingly. Where people required assistance from staff to eat their meal, this was provided sensitively, at the person's pace. People's likes and dislikes were clearly documented.

People had access to healthcare services and were supported to manage their health. Records showed that the service ensured suitable support from doctors, dentists, podiatrists, and many other speciality services was provided to meet people's needs. Healthcare professionals told us staff communicated well with them and followed their advice.

The home was not purpose built to accommodate older people and consequently, whilst having a very homely atmosphere, some parts of the home did not easily meet people's needs. For example, there were various different levels in the building with small flights of stairs and some corridors were narrow which made access with equipment such as wheelchairs more difficult. The registered manager confirmed that they were aware of this and allocated rooms to people which would best suit their needs including offering different rooms to people as their needs changed. They also stated that the refurbishment work was designed to address some of these issues.

Some of the people in the home were living with dementia. Signage and equipment was not always clearly adapted to assist people living with dementia: for example, research has shown that strongly coloured toilet seats help people recognise the lavatory and therefore supports them with continence. The registered manager acknowledged this and confirmed that this type of work was included in the final part of the refurbishment project.

Good

Is the service caring?

Our findings

People described staff as caring and approachable and confirmed that they received help and support when they rang their call bell or asked someone. Relatives told us that they were happy with staffing levels in the home and they always received a warm welcome.

Throughout our inspection we observed people were treated with dignity and respect by staff. There was a relaxed, friendly atmosphere in the home. People were offered choices about what they would like to do and where they would like to sit. Staff knocked on people's bedroom doors before entering their rooms and called people by their preferred name. Personal care was carried out in people's bedrooms to ensure their privacy was maintained. People's care records were kept securely in a lockable room and no personal information was on display.

Staff spoke knowledgeably about the people they cared for; they explained what people's needs were and how people liked to have their care provided. They also knew what their likes and dislikes were and in many cases, knew the person well enough to be able to chat with them about family, friends and past experiences.

There were positive interactions between staff and the people they were supporting. Staff had a good rapport with people.

People's views and preferences for care had been sought and were respected. People's life histories, their important relationships, hobbies and previous life experiences were documented in their care plans. The records included detail about how people preferred to spend their day, their night time needs and what social activities and hobbies they enjoyed. This information was useful for staff to get to know the person well and provide activities they enjoyed.

Relatives told us they felt communication in the home was effective and told us staff were good at keeping them up to date with how people were and whether they needed anything such as items of shopping.

People were smartly dressed, clean and comfortable. People who used aids such as hearing aids or glasses were wearing them and people had their watches or jewellery, such as a necklace or earrings, on where they chose to.

People's bedrooms were personalised with items of their furniture, ornaments, pictures and photographs of people who were important to them.

Requires Improvement

Is the service responsive?

Our findings

A relative told us, "I don't think [person's name] would still be with us if it wasn't for the care here." They went on to explain to us that the person lived with dementia and the steps the service had taken to meet the person's needs. They also told us that the service had arranged for family members to attend information sessions about dementia which had helped them to understand better and re-connect with the person.

People had their call bells positioned near them so that they could summon assistance whenever they needed to. They told us staff responded quickly to their requests for assistance. Many people were unable to use a call bell. Staff were aware of who these people were and made additional checks to ensure that they were comfortable and offer any support that may be required.

Care plans and assessments were not always accurate, complete and contemporaneous. This meant that there was not always information about people's needs and how staff should provide support to ensure people's needs were met. For example, some people were living with conditions such as Parkinson's disease or diabetes. There was no overview to guide staff about the condition, how it specifically affected the person concerned and any actions the staff needed to take to ensure the person was fully supported. The registered manager advised that they believed much of this was because the newly introduced computerised care planning system did not appear to give staff this option.

Body maps had not always been created whenever an injury, wound or mark to skin was identified. Where body maps had been created, these had not updated to confirm when areas had healed or when any other action had been taken.

The service provided six interim care beds in conjunction with a local hospital. This meant that people who were fit to leave hospital but needed some extra support before returning home could stay at Windsor Court for the support they needed for a period of six weeks. Some of the care plans for people who were newly admitted to the home lacked information and details about their needs and how these should be met. Other care plans contained conflicting information. For example, computer records for one person stated that they were continent. Staff handover records stated that the person had a catheter to support their continence needs and no wounds. A separate skin integrity care plan stated that the person was incontinent of faeces, had an open sacral sore and a cut on their arm.

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

An activities organiser was employed by the service and worked from 8.30am to 4pm from Monday to Friday each week. Activities were available over weekends and these were led by care staff who followed plans set out by the activities staff. There was a timetable of activities available on notice boards around the home and also in people's rooms. There was a planned activity each morning and afternoon. These included two afternoons where activities staff spent time with individual people who sometimes preferred not to engage in group activities. The remaining planned activities were all group activities and included quizzes, bingo,

cooking and darts. The activities programmes did not always reflect the information that was known in care records about people's hobbies, likes and interests. The activities organiser spoke very enthusiastically about the plans they had and activities which they hoped to introduce. They told us that they had not completed any training in providing suitable activities but said they believed the registered manager was looking into this. The registered manager confirmed that the provision of suitable activities was an area that they were planning to improve and also told us, following the inspection that the member of staff had received training from the Alzheimer's Society and the In-Reach team for the provision of activities.

The Accessible Information Standard is a law that aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The registered manager was not aware of the Accessible Information Standard. However, they demonstrated that they were aware of people's sensory loss and communication needs and had previously taken steps such as printing documents in large print or reading documents aloud to people. Staff also confirmed that they provided the support people required in these areas.

We recommend that the registered manager takes steps to familiarise themselves with this standard and ensures that people's needs are recorded appropriately.

People were supported, at the end of their lives, to die in comfort and with dignity. Staff liaised with GPs and district nurses to provide the support needed, for example ensuring that anticipatory end-of-life medicines were in place. Staff discussed with people and their families' preferences regarding end of life care, if they were willing to discuss this. Any information was recorded in the person's care plan including whether the person had preference to stay at the home or to go to hospital. No one was receiving this care at the time of our visits however we saw letters and cards that had been sent by relatives of people who had died recently. These expressed appreciation for the care and support people had received.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint. Complaints raised had been addressed in a transparent manner and within the timescales laid out in the provider's policy. Where learning needs were identified it was clear that this had been acted on with individual staff members.

Requires Improvement

Is the service well-led?

Our findings

All of the people and visitors we spoke with were positive about the registered manager and the way the home was managed. People and relatives told us that there were always staff available to them if they had queries or concerns and that they knew the registered manager was available for them should they need her. They added that they knew that they would be listened to and that action would be taken if they raised concerns.

Staff spoke highly of their manager and colleagues and told us they were all motivated to do the best for people.

The service had a clear management structure with the senior staff and deputy manager all reporting to the registered manager. Support and additional line management was provided by the registered provider. The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications, had been complied with.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual access to computer based records and rooms containing records were locked when not occupied by staff.

The senior team were open in response to inspectors and we saw that they identified opportunities for learning and shared these with staff and relevant professionals. There was a culture of openness evident in their actions and in the way staff communicated with each other. Staff told us they would be confident to whistle blow if this was necessary.

The registered provider had a quality assurance process that included regular visits from the registered provider. The registered manager and senior staff also undertook audits. We found that these had not always been effective. This was because audits of areas such as infection prevention and control, cleaning and medicines had not identified the issues found at this inspection.

Some records, such as care plans and assessments, lacked detail and important information and had not been created in a timely way. Other records contained conflicting information which meant that it was not clear what people's needs were and how these were to be met. Again, audits of care plans had not identified these issues.

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

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 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's health and safety whilst receiving care had not been properly assessed and action had not always been taken to mitigate any such risks. People were not protected against the risks associated with the unsafe management and use of medicines. Systems and procedures to keep the house clean and prevent and control the spread of infection were not always robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not always been effective in monitoring the quality and safety of the services provided. Detailed and accurate records had not always been maintained.