Abbey Health Care Limited

Abbey Court Nursing Home - West Kingsdown

Inspection report

School Lane
West Kingsdown
Sevenoaks
Kent
TN15 6JB

Tel: 01474854136

Date of inspection visit:
17 December 2018

Date of publication:
04 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 17 December 2018. The inspection was unannounced. Abbey Court Nursing Home – West Kingsdown is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Abbey Court Nursing Home – West Kingsdown is registered to provide accommodation, nursing and personal care for 22 older people and people who have physical adaptive needs. There were 13 people living in the service at the time of our inspection visit. The service was run by a company who was the registered provider. The company was owned and operated by two directors one of whom was also the 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.

At the last comprehensive inspection on 7 November 2017 the overall rating of the service was, 'Requires Improvement'. This was because our domains 'responsive' and 'well led' were rated as 'Requires Improvement'. In relation to our domain 'responsive', nurses and care staff had not been fully supported to consistently provide people with person-centred and responsive care. This was because care plans that were intended to describe the assistance people had agreed to receive were not sufficiently detailed to guide nurses and care staff to provide care in the way people preferred. In relation to our domain 'well led', we found that sufficient provision had not been made to ensure that people who lived with dementia were suitably supported to pursue their hobbies and interests.

At the present inspection we found that although progress had been made more still needed to be done to address both these shortfalls.

In addition to this we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were shortfalls in the provision made to ensure people consistently received safe care and treatment. These included oversights in the support people received to manage healthcare conditions, fire safety, the management of medicines and the prevention and control of infection. There were also shortfalls in the systems and processes used to monitor, assess and improve the quality of the service. You can see what action we have told the registered provider to take at the end of the full version of this report.

We also raised other concerns with the registered manager in relation to which we have made recommendations. These recommendations were because of shortfalls in the deployment of staff and the provision of reassurance to people who lived with dementia. They also referred to the provision of care that promoted people's dignity and the arrangements made to support people to make and review decisions about their care.

Due to these shortfalls we have again rated the service as, 'Requires Improvement. This is the third consecutive occasion when we have rated the service as, 'Requires Improvement'.

Our other findings are as follows: Recruitment checks for two care staff had not been completed in the right way. People were safeguarded from situations in which they may experience abuse. Lessons were learned when things had gone wrong.

The accommodation was not designed, adapted and decorated to meet people's needs and expectations. People had been supported to eat enough to have a balanced diet. Suitable arrangements were in place to obtain consent so that people only received lawful care. People receive coordinated care when they moved between different services and they had been helped to obtain any healthcare they needed.

People's right to privacy was not always respected. People were supported by relatives, friends and representatives to make decisions about things that were important to them. Confidential information was kept private.

Equality, diversity and inclusion were promoted. There were arrangements in place to resolve complaints. People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Nurses and care staff were supported to understand their responsibilities. This included speaking out if they had concerns about the wellbeing of a person who lived in the service. The registered provider had informed the Care Quality Commission of important events that had happen in the service. The quality rating we gave the service at out last inspection had been displayed in the service and on the registered provider's website. The registered manager was actively working in partnership with other agencies to support the development of best practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were shortfalls in the arrangements made to ensure that people received safe care and treatment. These included the management of healthcare conditions, management of medicines, fire safety and the prevention and control of infection.

Robust arrangements had not been made to ensure that sufficient numbers of care staff were always on duty.

Background checks had not been completed in the right way before two new care staff had been appointed.

People were safeguarded from the risk of abuse.

Accidents and near misses had been analysed so that lessons could be learned to help keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Nurses and care staff had not been fully supported to provide care that delivered positive outcomes to people who lived with dementia and who needed reassurance.

There were shortfalls in the design, adaptation and decoration of the accommodation.

People were supported to eat and drink enough to have a balanced diet.

There were suitable arrangements to obtain consent to care and treatment in line with legislation.

People receive coordinated care when they used different services.

People had been supported to receive on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care that promoted their dignity.

People's right to privacy was not always respected.

People had been supported to make decisions about things that were important to them.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been fully supported to make and review decisions about their care.

People had not been offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Suitable arrangements had been made to promote equality, diversity and inclusion.

There were arrangements in place to resolve complaints.

People had been supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were shortfalls in the systems and processes used to assess, monitor and improve the quality and safety of the service.

Nurses and care staff had been supported to understand their responsibilities including speaking out if they had concerns about the wellbeing of people who lived in the service.

The registered provider had told us about incidents that had occurred in the service and the lessons that had been learned.

The quality rating we gave the service at out last inspection had been displayed in the service and on the registered provider's website.

The registered manager was working in partnership with other agencies to promote the delivery of joined-up care.	

Abbey Court Nursing Home - West Kingsdown

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 registered provider continued to meet 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.

We used information the registered provider sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered provider had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We visited the service on 17 December 2018 and the inspection was unannounced. The inspection team consisted of an inspector, a special professional advisor and an expert by experience. The special professional advisor was a nurse. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

During the inspection visit we spoke with six people who lived in the service and three relatives. We also spoke with two nurses, three care staff, the activities coordinator and the chef. In addition to this, we met with the registered manager. We observed care that was provided in communal areas and looked at the care records for seven people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of two people who lived with dementia and who could not speak with us.

Requires Improvement

Is the service safe?

Our findings

We asked six people who lived in the service if they felt safe in their home and all of them gave a positive response. One of them said, "Yes, I do feel safe here because the staff are kind and I get treated in the right way." Two of the three relatives with whom we spoke were also complimentary. One relative said, "The home has a nice family atmosphere; it is like an Edwardian home, with a very familiar feel. My family member is always smiling she sees the carers as her friends."

However, we found that people did not always receive safe care and treatment. This was because robust arrangements had not been made to support one person to effectively manage a healthcare condition. The person's health needed to be carefully monitored so that a doctor's advice could quickly be sought if they were becoming unwell. However, on three occasions when the person's health had deteriorated during the four weeks preceding our inspection visit suitable action had not been taken. Although care records showed that the person had not experienced actual harm, the shortfall had increased the risk of this occurring.

In addition to this, suitable provision had not been made to ensure that three people were consistently supported to keep their skin healthy. We noted that a healthcare professional had said that the people concerned needed to rest on special pressure-relieving mattresses. These mattresses need to be set to the correct pressure so that they give the right cushioning effect. Nurses and care staff told us that they had carefully checked to ensure that the mattresses were working in the right way. However, these checks had not been recorded. Consequently, the registered persons could not confirm that the checks had been completed in the right way to reduce the risk of the people concerned developing sore skin.

There were also limited shortfalls in the management of medicines. Although medicines were ordered and disposed of in the right way, suitable provision had not been made to guide nurses when administering three medicines that a doctor had said could be given on a discretionary basis. This was because nurses had not been given clear guidance to follow when deciding when to administer the medicine and how much to use. This had increased the risk that the medicines in question would be administered incorrectly or inconsistently. A further shortfall was because nurses had not carefully checked the stock of some medicines held in the service. When we checked one of these medicines we found that the number of tablets actually present was not correct. This oversight increased the risk that mistakes in the administration of the medicine concerned would go unnoticed. Also, that additional stock would not be requested at the right time. Although care records showed that the shortfalls above had not resulted in people experiencing direct harm, they had increased the likelihood of medicines not being used in a safe way.

People had not been fully protected from the risk of fire. Although the service was fitted with a modern system to detect, contain and fight fire we found that one of the designated fire escape routes was partially obstructed by flammable items of equipment that had been stored there. This was the case even though the registered provider had already completed a risk assessment that highlighted the need for all fire escape routes to be kept clear so that people could quickly evacuate the premises should the need arise.

We also found limited shortfalls in the arrangements that had been made to prevent and control infection.

The tap fitted to one of the communal baths could not be fully turned off and was dripping. This had resulted in one part of the bath becoming stained with lime-scale and green slime. The carpet in the main hallway, on the stairs and on the main landing was worn and badly stained. In addition to this, one of the communal wheelchairs was fitted with a cushion that was not clean and had a stale odour.

We raised all these concerns with the registered manager who assured us that steps would immediately be taken to address each of the shortfalls.

Failure to provide safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust arrangements had not been made to ensure that sufficient numbers of care staff were always on duty. This was because the registered provider had not used a nationally recognised system to calculate the number of care staff who needed to be on duty to promptly provide people with the care they needed. As a result, we could not be confident that changes in people's needs for care would quickly be identified and reflected in the number of care staff deployed in the service. We asked six people who lived in the service and three relatives to tell us if enough nurses and care staff were usually on duty. Three people and one relative voiced reservations. One of the people said, "The staff haven't the time to sit and chat with me in my room they are working too hard when they do have time they chat to me. We could do with more staff."

During our inspection visit we observed that there were enough nurses and care staff on duty. This was because we saw that on most occasions people promptly received the nursing and personal care they needed. On the limited number of occasions when this was not the case, the delay was not too long and did not result in the people concerned experiencing any inconvenience. We examined the staffing roster for the two weeks preceding our inspection visit. It showed that sufficient nurses and care staff had been deployed to meet the minimum level specified on the staff roster.

We recommend that the registered provider use a recognised tool to calculate how many care staff need to be on duty to ensure that people's changing needs for care are fully reflected in the deployment of care staff.

There were limited shortfalls in the checks that had been completed when recruiting two new care staff. These background checks are necessary to ensure that only suitable and trustworthy people are employed in the service. In both cases the registered provider had not obtained a full and continuous account of the applicants' previous periods of employment. This had reduced the registered providers' ability to establish the applicants' previous good conduct.

However, references had been obtained in relation to the periods of employment that were known. In addition to this, the registered provider had in each case obtained a clearance from the Disclosure and Barring Service. These disclosures are necessary to show that the applicants had not been guilty of a relevant criminal offence or professional malpractice.

We raised our concerns with the registered manager who assured us that the service's recruitment procedure would immediately be strengthened to address the shortfall we had identified.

People were suitably safeguarded from situations in which they may experience abuse. Records showed that nurses and care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. The registered manager said and care records confirmed that they had carefully considered each occasion when

a person had sustained a minor injury such as a bruise. This was so that the causes of each injury could quickly be established and if necessary action taken to keep the person safe.

Records of incidents that had occurred in the service showed that the registered manager had analysed accidents and near misses so that lessons could be learned to help keep people safe. This involved establishing what had gone wrong and what needed to be done to help prevent a recurrence. An example of this was people who were at risk of falling being referred to specialist health care professionals so that care staff could be advised about how best to keep the people concerned safe.

Requires Improvement

Is the service effective?

Our findings

We asked six people if they were confident that nurses and care staff knew what they were doing and had had their best interests at heart. All of them were complimentary in their replies. One of them said, "The nurses and the care staff here are good and over time we've worked out how I like to be helped and they do what they need to." All the relatives with whom we spoke were also positive in their comments. One of them said, "I do think that the staff are very helpful and they really do care for my family member."

However, we found that care staff had not been fully supported to consistently provide care in line with national guidance to promote positive outcomes for people who lived with dementia. Records showed that nurses and care staff had undertaken introductory training followed by more detailed training in a range of key subjects including how to safety assist people who have physical adaptive needs and how to support people to promote their continence. They had also undertaken training in how to respond effectively to people who live with dementia and who may express themselves in ways that put themselves and others around them at risk of harm. In addition to this, nurses and care staff had met with the registered manager on a one to one basis to review their work and to receive support and guidance.

Nevertheless, three care staff told us that they would like additional training and guidance in relation to supporting people who live with dementia. We found that this lack of confidence was reflected in the support two people received when they were becoming distressed and needed reassurance. We saw one person expressing anxiety by calling out and moving their hands around in an uncoordinated way. One care staff did not intervene because they thought it was best to leave the person to become calm in their own time. However, another care staff adopted a different approach and gently held the person's hands to comfort them. This approach was also unsuccessful because the person became increasingly upset. Eventually, a third care staff realised that the person was indicating that they wanted to be assisted to have a drink after which they became relaxed and smiled. In relation to the second person, two care staff adopted inconsistent approaches when the person was knocking on the table beside their armchair to indicate that they were worried about something. One of them attempted to move the table out of the person's reach. This resulted in the person knocking on their knee instead. After a short while another care staff moved the table back to its original position but then made no further attempt to give reassurance. The person again began knocking on the table with an increased frequency and volume. This continued until a third care staff recognised that the person was asking to be assisted to go to the bathroom. In both instances, the people concerned received inconsistent care that did not promptly respond to their needs for reassurance.

We recommend that the registered provider consults national guidance about how to support care staff to respond effectively to people who live with dementia and who need reassurance.

The accommodation was not designed, adapted and decorated to meet people's needs and expectations. There were three defects that detracted from people's ability to live in a homely setting. The foyer and hallway on the ground floor was being redecorated and as a result the walls had been stripped back to the plaster and a central heating radiator had been removed. The area looked unsightly and the registered manager was not able to tell us when it would be returned to a normal domestic standard. In the

lounge/dining area a small window could not be fully closed to achieve a weather-tight seal. This was because the latch and frame were broken. A further defect was in one of the shower rooms where the controls for the operation of the shower had been crudely installed leaving exposed pipework that was unsightly.

We asked six people about the catering arrangements in the service. All of them said that they enjoyed their meals. One of them remarked, "The food here is very good really and I get more than enough." Another person said, "The food has got better since the new chef came and it's quite okay at the moment." There was a written menu which showed that there was a choice of dish served at each meal time. The meals that we saw served at lunchtime in the dining room were attractively presented and the portions were a reasonable size. The dining tables were neatly laid, the cutlery was clean and the meal time was a relaxed occasion. People dined at their own pace, chatted with each other and as necessary received assistance from care staff. Some people had chosen to dine in the privacy of their bedroom.

National guidelines had been followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. The Mental Capacity Act 2005 provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were suitable arrangements to obtain consent to care and treatment in line with legislation and guidance. The registered manager, nurses and care staff were supporting people to make decisions for themselves whenever possible. Also, when people lacked mental capacity the registered manager had ensured that decisions were made in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a decision needed to be made about people having rails fitted to the side of their bed. These are sometimes necessary so that a person can rest safely in bed without accidentally slipping and falling onto the floor.

The registered provider had made the necessary applications for DoLS authorisations. Furthermore, they understood the importance of checking to make sure that any conditions placed on authorisations were met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included nurses preparing written information likely to be useful to hospital staff when providing medical treatment. Another example of this was the registered manager offering to arrange for people to be accompanied to hospital appointments by care staff. This was so that important information could be passed on to healthcare professionals.

People were supported to receive on-going healthcare support. This included nurses referring people to see their doctor if they were not well. During our inspection we noted that a nurse telephoned a person's doctor. This was because they were concerned that the person was not responding well to the treatment prescribed for them. Records also showed that arrangements had been made for people to have consultations with professionals such as dentists, physiotherapists and opticians.

Requires Improvement

Is the service caring?

Our findings

We asked six people to describe their experience of receiving care in the service. Three of them were positive about all aspects of the care they received. One of them said, "I get cared for very well indeed and the staff are lovely to me."

However, three people were concerned that some of the nurses and care staff did not use English as their first language and were not sufficiently fluent to enable them to engage in normal conversation. One of them said, "Don't get me wrong the staff are kind but it can be a battle to make yourself understood and sometimes I just give up and don't ask for help because it's too much trouble to explain." Another person said, "When I try to speak to the staff they say me don't understand it is like speaking to a brick wall. If you ask people for a teaspoon they don't know what is. They didn't even know what a blanket was." One of the relatives with whom we spoke also voiced concerns about this matter. They said, "Communication is difficult because of the language problem. I mean I find it hard for me to understand them so how can older people who have dementia understand them."

We asked a nurse and a care worker who did not use English as their first language straight forward questions about the service. Our question to the nurse was 'How long have you worked in the service for?' and we asked the care worker, 'Do you think enough staff are on duty to care for people?'. Neither member of staff was able to understand our question. This was the case even after we had repeated them and attempted to explain our enquiries in more detail.

We were concerned to note two incidents when this lack of fluency in the use of English resulted in a person not promptly receiving all the care they needed. This was because a care worker did not realise that a person was asking to be assisted to the bathroom. This misunderstanding resulted in the person not promptly receiving the assistance for which they had asked. The second incident occurred when a person who was sitting in the main lounge asked a member of care staff to fetch a cardigan they had left in their bedroom. The member of care staff did not understand the word 'cardigan' even though the person gave a clear account of the garment in question. In the end our inspector assisted the conversation by indicating towards another person sitting nearby who was wearing a cardigan.

We raised our concerns with the registered manager who told us that they had provided some members of staff with additional training to improve their skills in speaking and writing in English. However, we found that this training had not been effective in addressing the problem.

We recommend that the registered provider consult national guidance about how to support all nurses and care staff to communicate effectively with people who live in the service to promote their dignity.

We found another example of a person not being fully supported to experience responsive care that promoted their dignity. We examined a record that listed the requests people had made during a recent 'residents' meeting'. The registered manager told us that people who lived in the service and their relatives were invited to refer to the record if they had not attended the meeting. This was so that they knew what

points had been raised. We were concerned to note that the registered manager had written that a person's request to access the garden was, "Quite unrealistic as they cannot walk." This response was disrespectful and did not address the request that had been made. We raised our concern about this matter with the registered manager. They accepted that more care needed to be taken when responding to a request such as this to ensure that people's dignity was consistently promoted. The registered manager also assured us that the person concerned had subsequently been assisted by staff to access the garden by using a wheelchair.

Most bedroom doors were fitted with locks and the registered manager told us that it was important for people to be offered the opportunity to secure their personal space. However, in practice this arrangement was poorly managed. This was because the registered manager could not confirm that people had in fact been offered the use of a key with which to lock their bedroom. We asked four people about this matter. None of them recalled being asked if they would like to be able to lock their bedroom door. Furthermore, three of them said that they would be interested in being able to do so. After the inspection visit the registered manager told us that one person had been provided with a key to enable them to secure their bedroom.

Most people had family, friends or solicitors who could assist them to make decisions about things that were important to them. Records showed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Furthermore, the registered manager had developed links with local lay advocacy resources. Lay advocates are independent of the service and can support people to weigh up information, make decisions and communicate their wishes.

People could speak with relatives and meet with health and social care professionals in private if this was their wish. We also noted examples of care staff assisting people to keep in touch with their relatives by post and telephone.

Confidential information was kept private. Written documents and records that contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff. We saw nurses and care staff speaking in a quiet and discreet way when discussing confidential information so that there was less chance of them being overheard.

Requires Improvement

Is the service responsive?

Our findings

Although people told us that they received a lot of practical assistance from nurses and care staff, we found that little had been done to enable people to be fully involved in making and reviewing decisions about the care they received. Each person had a written care plan that described the care they needed and had agreed to receive. The registered manager said these documents were regularly updated in consultation with each person to ensure that they accurately reflected people's changing needs and wishes. However, in practice people's care plans were kept locked away and were only available for nurses and care staff to see. Although records showed that the care plans had been regularly reviewed by the nurses to help ensure that they were up to date, this process had not involved the people to whom the care plans related. We asked six people about their experience of contributing to decisions about the care they received. Each of them told us that they did not know that a care plan had been prepared on their behalf and was supposed to reflect the assistance they had agreed to receive. One of them remarked, "It would be right I suppose to know a bit about what was written down about me."

In addition to this, we found that little had been done to meet the Accessible Information Standard that was introduced on 1 August 2016. This measure requires all providers of NHS care and publicly-funded adult social care to make suitable arrangements to support people who have information or communication needs relating to physical and/or sensory adaptive needs. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such as large print and graphics. However, we found that the care plans and daily records of the care provided were written in a formal management style and presented information using technical terms and abbreviations with which most people would not be familiar. This reduced the opportunities people had to become meaningfully involved in confirming that their care continued to meet their needs and expectations.

We recommend that the registered provider consult national guidance about how people who live in the service can be meaningfully consulted about the care they receive.

We asked six people about the opportunities they were offered to enjoy pursuing their hobbies and interests. Five of them said they were satisfied with the variety and frequency of the social activities in which they were invited to participate by the activities coordinator. One of them remarked, "I can join in with things such as games and quizzes in the lounge if I want to but there's no pressure. If I'm in my bedroom the activities coordinator will pop their head around the door to ask if I'm okay." The activities coordinator said and records confirmed that they met with people as soon as they moved into the service. This was done to find out what support they wanted to receive to pursue their hobbies and interests.

However, we could not establish how well in practice people who lived with dementia were being supported to enjoy social activities. This was because the activities coordinator could not access the electronic records they kept of each person's daily involvement in the calendar of social activities. We observed three people who lived with dementia over a period of 40 minutes when they were sitting in the main lounge. We were concerned to note that for most of this time each person was passive and was disengaged with their surroundings.

We recommend that the registered provider consult national guidance about how people who live with dementia can be offered a range of imaginative and innovative opportunities to pursue their hobbies and interests.

Nurses and care staff understood the importance of promoting equality and diversity. People were offered the opportunity to meet their spiritual needs by attending a regular religious ceremony that was held in the service. Nurses and care staff also recognised the importance of appropriately supporting people if they followed gay, lesbian, bisexual, transgender or intersex life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their choices.

There were suitable arrangements to ensure that people's complaints were managed in the right way. People had been informed about their right to make a complaint and how to go about it. The registered manager told us that since our last inspection they had received 10 formal complaints. There were records of the steps taken by the registered manager to investigate and resolve the complaints. They showed that suitable action had been taken to address the matters in question.

People had been supported at the end of their life to have a comfortable, dignified and pain-free death. This included consulting with people and their relatives to establish how best to support a person when they approached the end of their life. A part of this involved clarifying each person's wishes about the medical care they wanted to receive and the religious observances in which they wished to participate.

Requires Improvement

Is the service well-led?

Our findings

We asked six people to give us their views about how well the service was managed. Five of them were positive in their assessment. One of them said, "Overall, it's pretty good. I get the care I need, the meals are okay and the staff are kind." The person who expressed reservations told us, "Things take too long to sort out like the heating in my bedroom wasn't working for a while and should have been fixed sooner." Two of the three relatives with whom we spoke were also positive. One of them said, "I like the manager she is personable, interested and very chatty. I think the organisation of the home is okay."

The registered manager completed a number of quality checks that were designed to ensure that the service consistently provided people with safe and responsive care. However, we noted that these checks had not been sufficiently robust to quickly address the shortfalls we found during our inspection visit. These concerns included the support people received to manage health care conditions, the management of medicines, the recruitment of staff and the prevention and control of infection. There were further concerns about the promotion of positive outcomes for people who lived with dementia and the maintenance of the accommodation. Other concerns referred to the provision of dignified care that respected people's right to privacy, supporting people to make a review decisions about their care and the arrangements in place to enable people to pursue their hobbies and interests.

Failure to assess, monitor and improve the quality and safety of the services was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, arrangements had been made to support people who lived in the service and their relatives to suggest improvements. These included being invited to attend regular 'residents' meetings' at which people were offered the opportunity to give feedback about their experience of living in the service. We also noted that relatives had been offered the opportunity to complete questionnaires to give feedback about how well the service was performing. There were examples of suggested improvements being put into effect. One of these involved changes that had been made to the menu so that it provided more choice and variety.

There was a registered manager who had a detailed knowledge of how the service operated. 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.

There were a number of systems and processes that were designed to enable nurses and care staff to work as a team and to contribute to regulatory requirements being met. There was a nurse in charge of each shift and member of the senior management team was on call during out of office hours to give advice and assistance should it be needed. Nurses and care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision helped to ensure that care staff were suitably supported to care for people in the right way. Furthermore, nurses and care staff had been provided with written policies and procedures to give them guidance about their roles.

Nurses and care staff told us there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is necessary so that we can check that appropriate action has been taken. We noted that the registered provider had submitted notifications to us in the correct way.

It is a legal requirement that a provider's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered provider had conspicuously displayed their rating both in the service and on their website.

The registered provider was working in partnership with other agencies. The registered manager had attended local 'registered managers' forums'. This was important so that the service could benefit from sharing ideas with other providers about how to develop best practice in the provision of safe and responsive care.

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 registered provider had not consistently provided people with safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not suitably assessed, monitored and improved the quality and safety of the service.