

# Orchard Care Homes.Com (2) Limited

## Clipstone Hall and Lodge

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

We undertook this unannounced inspection on 7 February 2018. The service provides residential and care for 90 people who are living with Dementia. On the day of our inspection 62 people were using the service. Clipstone Hall and Lodge is a 'care home'. People in care homes receive accommodation and 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 is provided over five units. Three units, over three floors in the Lodge and two units in the Hall.

The service had a registered manager in place at the time of our inspection. 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 and associated Regulations about how the service is run.

Medicines were not managed safely, and as a result a person had received out of date medicines that may not have been effective. Some people who required medicines at particular times for a health condition had not received their medicines in a timely way. This had not been picked up through the provider's governance processes. We have made a recommendation about this.

People were not always protected from risk as there was a lack of essential information in some people's risk assessments, and staff could not always tell us how risks to people's safety were managed.

People were protected from the risk of abuse and staff had a good understanding of their roles and responsibilities if they suspected abuse was happening. The registered manager shared information with the local authority when needed and acted on concerns when they were raised to them. The service reviewed safeguarding issues to learn from incidents and prevent reoccurrence.

Staffing levels in the service were sufficient and the registered manager regularly reviewed staff levels to ensure that they remained safe. However, deployment of staff in one area of the service had a negative impact on some people.

The cleanliness of the service was maintained and monitored and staff were knowledgeable on how to protect people from the risks of infection. Staff had a full understanding of people's care needs and received regular training and support to give them the skills and knowledge to meet these needs.

People were protected from the risks of inadequate nutrition and dehydration. Specialist diets were provided if required. Referrals were made to health care professionals when needed. People lived in a service which met their needs in relation to the premises and adaptations were made where required.

Staff understood the importance of obtaining consent when providing care and there were mental capacity

assessments in place for people who lacked the capacity to make a decision. However prior to our inspection the registered manager had identified that the service had not always followed the principles of the Mental Capacity Act (2005) when undertaking these assessments. The registered manager had already started to address this issue by reviewing the assessments to ensure the principles of the MCA would be followed in the future

People who used the service, or their representatives, were encouraged to contribute to the planning of their care. They were treated in a caring and respectful manner by staff who delivered support in a relaxed and considerate manner.

People, who used the service, or their representatives, were encouraged to be involved in decisions about their environment, and systems were in place to monitor the quality of service provision. People also felt they could report any concerns to the management team and felt they would be taken seriously.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## 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,

People's medicines were not always managed safely.

The assessment of risks to people was inconsistent with some records lacking essential information to allow staff to manage people's care.

Staffing levels met the needs of people, but there was a lack of efficient deployment of staff in some areas of the service, which had a negative impact on people's care in that area.

The risk of abuse to people was minimised because the provider had systems in place to recognise and respond to allegations or incidents of a safeguarding nature.

People were protected from the risk of infection.

### Is the service effective?

**Good** 

The service was effective.

People were supported by staff who received appropriate training and supervision. Nationally recognised tools were used to assess people's needs.

People lived in a service which met their needs in relation to the premises and adaptations were made where needed.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Where people lacked the capacity to make a decision the provider had not always followed the principles of the Mental Capacity Act (2005). However, the registered manager had already begun to address this issue prior to our inspection.

### Is the service caring?

**Good** 

The service was caring.

People were supported by staff who knew them well and had a kind, caring and respectful manner when providing care.

People were able to contribute to their care planning and their views were considered.

Staff supported people to maintain their dignity and privacy.

### **Is the service responsive?**

The service was not always responsive.

The information in people's care plans did not always reflect the care they required or received. People felt the range of activities offered did not always meet their needs.

Complaints were dealt with in line with the company's complaints policy.

People's end of life wishes were not always discussed with them. However, staff worked to ensure people's physical needs were managed.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well-led

The management team was visible and supportive.

There were systems in place to monitor the quality of the service. However, they needed to be more robust at highlighting issues of concerns.

People's, relative's and staff views were listened to and ideas implemented.

The service worked with members of the local community to develop relationships to support the service.

**Requires Improvement** ●

# Clipstone Hall and Lodge

## **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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 February 2018 and was unannounced. The inspection team consisted of two inspectors, an inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of caring for someone who uses this type of care service. Their specialist area was the care of older people and dementia.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved with the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with 14 people who used the service, six visiting relatives, six care staff, two housekeepers, one of the deputy managers and the registered manager. We also 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 looked at all or part of the care records of nine people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service.

# Is the service safe?

## Our findings

People's medicines were not always managed safely. Although staff had received training in safe handling of medicines and had regular observation of their competency, we found a number of practices that put people at risk of receiving out of date medicines. For example, a liquid medicine used for pain relief on an 'as required' basis for one person was received at the service in December 2015. Approximately four doses had been administered during 2016 and 2017. However the instructions on the bottle clearly showed the medicine should have been discarded after three months of opening. This meant the person had received medicine that may not have been effective. The person's Medicine Administration Record (MAR) lacked any clear instructions to show when and why staff should administer this medicine. This meant the person may also have received this medicine inappropriately. We viewed a number of other MARs and noted the lack of specific instructions to assist staff making decisions to administer medicines on an as required basis. We discussed this issue with the registered manager who accepted there should have been clear instructions in each person's MAR to assist staff when making decisions to administer this medicine. They told us they would address this issue.

We found other liquid medicines, dated when they were received at the service but not labelled with the date of opening. Some liquid medicines were over six months old and partially used, therefore their effectiveness was questionable. Some people at the service required medicines to be given at specific times due to a health condition. We asked staff about the arrangements to ensure people received these medicines regularly and at the same time each day. The two staff we spoke with did not have a system for ensuring people received these medicines at the same time each day. This lack of clear timescales could have an effect on a person's daily health.

The risk to people's safety were not always assessed and managed to reduce particular risks. Some records we viewed did not contain information to show what measures were in place to keep people safe. For example a person's records noted they were at risk of choking, but there was no choking risk assessment and no evidence in their care plans of referral to a speech and language therapist for assessment. Following our inspection the registered manager told us they had addressed this.

A further person who at times displayed some challenging behaviour had been involved in an incident with another person who used the service. Whilst we saw there was some information in one of the care plans. The person who displayed the challenging behaviours had no records of the incident other than an entry in the health professionals' communication section of the care plan. This had noted the G.P planned to refer the person to another health professional for an assessment. However, there was no further information in the care plan to show if staff had followed this up and the staff we spoke with could not tell us if an assessment had been undertaken. It was noted in the person's care plan that behavioural monitoring charts should be used so staff could look for patterns of behaviour in the person. There was no behavioural chart in the person's record relating to the above incident. This meant staff were not consistently monitoring the person's behaviours. In addition, clear records had not been gathered to support any referrals to health professionals that would allow them to make consistent judgements about people's care needs.

The person's care plan also noted staff should use distraction techniques and not be confrontational with the person to support them and reduce challenging behavioural patterns. However, on one behavioural chart we viewed regarding an incident when the person displaying challenging behaviour, a member of staff had recorded they had told the person "not to do that." There was no further information on the chart to show the member of staff had followed the care plan and used distraction techniques to calm and support the person. This meant the member of staff might not have had sufficient knowledge of the person and their care plan to allow them to support the person in the most appropriate way.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person received oxygen, there was a risk assessment in place but this had not been reviewed since July 2017. The person used an e-cigarette and their oxygen risk assessment noted they were not to charge the e-cigarette in their room. However, the person's plans did not show how the person's care was managed when they left their bedroom to use the e-cigarette. Staff told us the person did not take their oxygen with them but there was no information on how staff were monitoring the person during these times in relation to their breathlessness. The person's care plan lacked any other information for staff on how often the person was using the e-cigarette or what support they needed in relation to this. We raised this with the registered manager who told us they were working with the person to support them in reducing the use of the e-cigarette, but would address our concerns. Following our inspection the registered manager sent us information to show this had been addressed.

There were some risk assessments that contained clear information for staff on the management of people's needs. For example, one person was assessed as a very high risk of falls. The risk assessment clearly showed the rationale for the assessment with the measures in place to reduce these risks. This included the use of a frame, sensor mat and encouragement to sit in the communal areas during the day so staff could closely monitor and support them. During our visit we saw staff working with the person, helping them use their frame and directing them while enabling them to be as independent as possible.

Some people and relatives told us they felt there was a lack of staff to support people with their needs. One person said, "I do sometimes have to wait a long time if I want to go to the toilet." Staff we spoke with felt, overall, the staffing levels were sufficient to meet people's needs. One member of staff said they were able to complete the care people required with the current staffing levels but more staff would be useful.

On the day of our inspection we saw there were enough staff to meet people's needs; however, we noted on one unit, the deployment of staff had resulted in one person not receiving the support they required with their meal. We discussed the staffing levels and deployment with the registered manager. They explained they regularly reviewed staff levels using the company's dependency tool and felt confident the staff levels met the needs of the people at the service. They told us they would address and monitor the issue of staff deployment so people received the right level of care in the future.

Safe recruitment practices were followed. Staff employed at the service had relevant pre-employment checks before they commenced work, to check on their suitability to work with people. This included criminal records check and employment history.

People who use the service told us they felt safe at Clipstone lodge. One person said, "This is a very safe place." Another person said, "I feel very safe as the staff look after me really well." Relatives told us they had confidence in the staff at the service, and one relative told us their loved one had told them how safe they

felt with the staff who cared for them.

Staff were aware of the signs of abuse and said they would report concerns to the manager. They said they could go to the CQC if the manager did not listen to them. One member of staff told us they felt people were safe at the service, they said they would not hesitate to report any abuse they saw.

Staff had confidence the management team would deal with any safeguarding concerns and were able to highlight issues of concern they had raised, and how these had been dealt with positively by the management team so there were good outcomes for people. One member of staff discussed how they managed people's behaviours to avoid potential safeguarding issues between people who lived at the service. Staff were clear what types of abuse people could be exposed to and what their role in managing this was.

The registered manager fulfilled their role in managing safeguarding incidents. They reported any concerns to both the local safeguarding team and ourselves, undertook investigations and responded to advice and guidance to assist them to reduce any possible future safeguarding concerns. The management team used the daily meetings to discuss any issues, to ensure staff learned from incidents. When individual staff members were involved in particular incidents. They also had individual lessons learned meetings to discuss the impact and what support they would need to prevent reoccurrence. For example, the registered manager emailed us following our inspection to show how they had learned from the medicines issue discussed above. They told us all staff and deputy managers have had lessons learned session in relation to the incident. All trolleys, bottles and boxes were checked to ensure they had not expired and guidance was sought from their pharmacist, who had also added further safety checks for staff when medicines were dispensed to the service.

People were protected against the risks of infection as the staff at the service showed a good knowledge of how to manage outbreaks of infection. People we spoke with told us the service was kept very clean and there were no malodours around the service. Housekeeping staff we spoke with discussed their cleaning processes and the cleaning schedule they completed to document the areas cleaned each day. They showed a good knowledge of the use of personal protective equipment and on the day of the visit we saw staff using this equipment appropriately.

# Is the service effective?

## Our findings

People's needs and choices were assessed using evidence based guidance and staff caring for them had the necessary tools to provide good care. The assessment tools the service used to assess people's needs were nationally recognised tools that helped the provider to deliver consistent care for the people they supported. The registered manager was aware of the Equality Act and their responsibility to ensure people at the service were not discriminated against. They told us the provider had a policy in place to ensure staff were aware of their responsibilities in relation to ensuring people were treated fairly. They were planning to highlight his policy to staff through their policy of the week programme, which meant the policy would be displayed in the staff room for discussion and aspects of the policy would be discussed at daily meetings.

People were supported by staff who received regular relevant training to assist them in their roles, and people and relatives told us they appeared to be well trained. Staff told us they had been supported with training in area such as managing behaviours, supporting people living with dementia, as well as tissue viability and end of life care. New members of staff were supported with an induction into their role and where required new staff undertook the care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The registered manager said they had worked with the health professionals who visited the service to ensure the training was as up to date and relevant to staff's roles as possible. The district nurses had also undertaken a training session on managing urinary tract infections. The training matrix showed staff received regular mandatory training in areas such as moving and handling, health and safety and fire training. Staff told us they had the opportunity to undertake some nationally recognised qualifications in care to assist them to remain up to date with their knowledge how to provide good care for the people they supported.

People's nutritional needs were well managed by staff caring for them. One person we spoke with told us, "I really like the food. I can't have dairy because I'm allergic and they are very careful to give me the right things without any milk." Relatives we spoke with were happy with the support their loved ones received to assist them maintain a healthy diet. One relative said, "I think the food here is good and [name] has put on some weight since they have been here which shows [name] is eating well."

The care plans we viewed showed what measures had been taken when a person's weight fluctuated. The regular monitoring of people's weights was undertaken and when needed an action plan to address issues was put in place. This showed what actions had been taken such as referral to the appropriate health professional and the implementation of any specialist diet. This showed the registered manager ensured the staff who cared for people had a good oversight of their dietary needs.

During our inspection we saw many examples of how people were supported. Staff were able to sit with people and encourage and assist them with eating when required and there was adapted cutlery in place for people needed it. The staff we spoke with were knowledgeable about the different diets people required and the cook explained how they received up to date information from the care team leaders to ensure people received an appropriate meal. The cook and kitchen assistant came into the different dining areas at

lunch time to check if people were enjoying the meals they had prepared. It was clear the people knew the team and chatted about their enjoyment of the meal.

The registered manager told us there was a fluid champion on each shift. This was a staff member who ensured people who needed support and encouragement to drink received the support. The registered manager had also put posters up in the kitchens on each floor with pictures of different snacks that were '100 calorie boosters' so staff had a variety of choice to offer people.

People's healthcare needs were well managed and people had access to the G.P, chiropodist and optician who all came to the service. One person had suffered a fall and sustained an injury that had not initially been picked up at the hospital, Staff made sure they went back to the hospital and was re-examined when their pain and symptoms had not subsided. The person said, "The night staff were brilliant with me and really upset because I wasn't sleeping so they insisted on getting the doctor out to me. Then I was sent back to the hospital." They went on to say, "I don't know what I'd have done if the staff hadn't sorted it out for me." A GP who supported the service undertook a weekly round that captured any niggling health issues. Staff told us they felt people's health needs were well managed and had confidence in the senior care team to address any issues of concern they raised to them.

Each person had a hospital passport that accompanies them should they need to attend hospital. This has information on their health needs, medicines and any individual needs in relation to their daily care needs to support hospital staff provide care for the person.

People lived in a purpose built, well maintained building that was designed to keep people safe but allow them the freedom move around. The service had good signage in place to support people who lived with dementia. The registered manager told us a relative asked for a separate lounge for sitting with their loved ones. In response they had decorated a room at the service so there was a quiet lounge with book effects and old-fashioned furniture to give a relaxed environment. This had had a good response from relatives and residents.

People were supported to make decisions about their care and told us staff always checked to see if they were happy to receive care. One person said, "They are always asking me. Everything they do, they say is it okay." Relatives we spoke with told us they heard people being asked for consent prior to staff providing care.

Staff we spoke with showed some knowledge of the Mental Capacity Act (MCA) and we saw they had received training to support their knowledge base. The 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.

Where people lacked the capacity to make a decision the provider had not always followed the principles of the Mental Capacity Act (2005). Some care records we viewed contained mental capacity assessments and best interest decisions for some aspects of care. However, there were some gaps and inconsistencies. For example a checklist indicated a person who had been assessed as lacking mental capacity was not able to make decisions about their mobility and the use of bed rails but could make decisions about their medicines. However the registered manager was already aware they needed to undertake some work to improve these records so the principles of the MCA were being followed. The registered manager had already sought further support from the company's training department for staff undertaking these reviews.

People can only be deprived of their liberty to receive treatment and care 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). 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 were being met. The registered manager had made applications to the local authority and staff were aware of the outcomes of the authorisations.

## Is the service caring?

### Our findings

People were supported by staff who were caring and knew their needs and preferences. We received positive feedback on staff's behaviours towards people. One person told us that they didn't like the dark and staff always ensured there was a low light on for them all night. They said, "They (staff) are kindness itself." Another person said, "They're all nice to us. I really like being here." A relative said, "I wouldn't let anybody say a word against the staff here. They never walk away from you and they've always got time for you, never mind how busy they are."

Staff we spoke with felt their colleagues had a caring attitude towards people at the service. Our observations supported what people had told us as we saw a number of positive interactions between staff people and relatives. A number of times during the day, we saw staff giving reassurance to confused or distressed people, taking them by the hand or putting an arm around a shoulder, sitting with them, smiling and engaging in conversation. This behaviour was not restricted to care staff. When the housekeeping staff were cleaning people's rooms they spent time chatting to people. This led to a relaxed and pleasant atmosphere at the service for the people who lived there.

The staff we spoke with knew the people they were supporting well. This included their personal histories, cultural and religious needs and preferences about how they were supported. Staff knew about people's likes, dislikes and preferences. One member of staff described a person's preferences and what foods they enjoyed. Staff told us that people's care plans contained the information they needed to get to know people and how they liked to be supported. People told us they felt comfortable talking to staff and asking for support and that their requests for support were responded to.

People and their relatives told us they were supported to express their views on their care and had been able to contribute to their care plans. One person said, "I've been involved with my care plan and so have my relatives." The person also said their relative was coming later that day to discuss treatment the person was receiving for a health condition. A relative told us they had been given a form to complete that would give staff further information on how to manage their relative's care when the person was first admitted to the service. They went on to say, "I've never seen a proper care plan as such, but my relative can speak for themselves to be honest."

Although legal appointees supported some people for particular areas such as finance. No one at the service had required the service of an advocate. Advocates support people who are unable to speak up for themselves. There was information at the service on advocacy services available should people require one.

People we spoke with were happy with the way staff spoke with them, managed their privacy and maintained their dignity. One relative told us when they visited they were able to see how staff supported people. They said, "They (staff) cover people, close doors (of bedrooms) if they are going to do anything." They went on to say that staff had a nice attitude towards the people they supported.

Staff showed a good understanding of their role in maintaining people's privacy and treating them with

respect. One member of staff told us they felt strongly that people should be treated with dignity and respect. They told us they would make sure they closed doors and curtains, and kept people covered when they were providing care. Our observations confirmed what staff had told us. We saw that staff knocked on people's doors before entering and ensured people's dignity was maintained when supporting them to change position.

## Is the service responsive?

### Our findings

Whilst people told us they were treated as individuals and supported in the way they wanted to be, their care plans did not always reflect this. The information in people's care plans was variable. Although care plans had been developed for people's care and support needs, some lacked sufficient and consistent information to assist staff to give the individualised care people required. For example, one person's care record contained a body map showing the person had developed a red broken area on their skin. We could find no further information in the person's care plan to show how this issue was managed. It had not been recorded in the person's waterlow assessment and there was no information to show if staff had referred the person to the tissue viability nurse. A member of staff told us they had noted the pressure sore whilst on night duty and had passed this on to other staff, and the person's repositioning regime had been increased. However there was no documented information in the person's care plan and the instructions for staff appeared to be verbal instructions. This put the person at risk of receiving inconsistent and potentially unsafe care.

A further issue noted was when a person had suffered skin tears following an incident. The incident had been documented but the person's care plan contained no information on how their skin tears were being managed. It was not clear if there had been any intervention by the district nursing team. However, staff we spoke with told us they thought there had been. We asked if the person's legs were being dressed and staff we spoke with were not sure if the person still had dressings on their legs. We spoke to the person and checked their legs to find the skin tears had healed and the person no longer had dressings in place as they were not required. However, the lack of information in the person's care plan and staff's lack of knowledge also put this person at risk of receiving inconsistent care.

There was a risk people's end of life wishes may not be met. The registered manager told us senior staff had received training on how to manage end of life discussions with people and their relatives. However, staff at the service had not always discussed people's end of life wishes with them. A number of care plans that stated relatives had not wanted to discuss people's end of life care, but there was no further information to show this had been re-visited at an appropriate time. This meant staff caring for people at this important time may not always have known their wishes.

However staff we spoke with told us they supported people and their relatives at this difficult time by working to ensure people were comfortable. The district nursing teams and staff worked closely to manage people's changing physical needs in relation to pain, nutrition and skin integrity.

The registered manager fulfilled their duty under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. For example we saw when offering food choices to people staff used visual choices as well as asking them. Notice boards had information displayed in easy read formats and signage around the service was in easy read formats.

We spoke with the registered manager about how they considered people's rights and diverse needs at the

service. They told us they started this process before the person was admitted by discussing any religious beliefs or special requests for their care, working within the Equality Act to ensure staff supported people's needs. The registered manager also told us they completed customer satisfaction surveys. These asked people and their relatives if the home respected their individual choices and beliefs. The care plans we viewed showed there had been reviews and people's cultural and religious needs had been considered by the service.

Whilst we saw the provider had an activities programme in place to support people. A number of people we spoke with told us there were not enough activities in place to offer the stimulation people needed. One relative we spoke with said, "The staff are doing their best but there is nothing to stimulate people mentally. There are no good activities and people are bored."

Staff we spoke with also felt there needed to be more activities so people were less bored. A planned activity programme included events such as, tea and coffee mornings, film afternoons, or exercise sessions. Pampering sessions, art and crafts, bingo, religious service and tabletop board games were also included. However, we saw that some people in some parts of the service were sat for periods with nothing to do. The registered manager told us they had worked to improve stimulation for people at the service. For example, one of the unit's at the service housed a number of people with advanced dementia and the registered manager had recently completed a sensory room for people to use. On the day of the inspection, we saw staff using this room to support people with various activities. People clearly enjoyed and responded to these activities in this environment.

People told us they had not had any cause to complain about their care at the service and the majority of relatives were happy with the way complaints were managed. Although one relative told us, some minor concerns were not always addressed straightaway. Staff we spoke with were able to discuss how they managed complaints. One member of staff told us they would try to sort out any concerns or complaints if they could and would record what they had done. They were also aware of the need to report issues to the deputy or registered manager and know there was a formal complaints process people could use. They were aware of the importance of documenting concerns.

The registered manager managed complaints in line with the company's complaints policy. The service had responded to complaints made and a log of all complaints was kept with details of how they were managed. This allowed the registered manager to look at ways of reducing re-occurrence.

## Is the service well-led?

### Our findings

Relatives we spoke with told us they had confidence in the management team. One relative had been impressed by the way staff had handled their relation's admission from hospital. They told us the deputy manager who had supported them and had spent a lot of time with them. The member of staff had liaised with the hospital team to ensure a smooth transition for their relation. They went on to say, "You know who is in charge (each day) and it makes you feel confident (in the care being given)."

Staff we spoke with were happy with the management team. One member of staff said, "I love it here. I think it's well led." They went on to say, if staff needed support then the management team were "Brilliant." Another member of staff told us the management team had an open door policy and worked with them to sort out problems.

Our observations on the day of inspection showed staff were relaxed with the managers on duty. As the unit managers and deputy manager moved around the building, they showed good knowledge of the people who lived at the service greeting them by name. While people may not have known the individual manager's name, they greeted them in a relaxed familiar way.

The registered manager discussed how they worked to maintain openness at the service. They discussed how they supported staff in different ways dependent on their needs. They told us staff received supervisions which enabled them to discuss any concerns. As well as formal staff meetings, there were regular informal meetings in the home to update staff on any changes or new information. The registered manager told us these initiatives gave staff a chance to give feedback and offer their own opinions or ideas to improve the service.

The registered manager understood their responsibilities in relation to the legal requirement of their CQC registration. They had kept us informed through statutory notifications and other required information related to the running of the service. Our records showed they had responded to us when this was required. The service displayed their CQC rating from their previous inspection.

The registered manager used regular audits to monitor quality of the service. We identified some auditing processes needed to be more robust, such as the auditing of the management of medicines and care plans. However, the registered manager had responded to our concerns by working with their pharmacist and staff members to improve the way medicines were audited. Following the inspection they sent information to show the measures they had undertaken both medicines and care plans.

We recommend that the service seek advice and guidance from a reputable source about effective governance systems for care planning and medicines management.

We found other risks to people were well managed through the auditing processes. They analysed areas such as falls to look at trends to reduce the risk of falls for people at the service.

Where the service had external audits undertaken in areas such as infection control and prevention, or the environment, the registered manager had used the information to address issues of concern. We saw action plans showing how the registered manager and their team were managing these issues.

People who lived at the service and their relatives were encouraged to be involved in developing the service. Relative and residents meetings held every six months allowed people and their relatives to discuss the plans in the home and contribute ideas for improvements. The registered manager told us, one relative had asked for a staff photo board showing staff names and roles. A further request from other relatives was to see more photographs of people participating in activities, as they were not always aware of the activities people undertook. The registered manager put these initiatives in place and told us they had had a lot of positive feedback from relatives about the boards. The registered manager took this further by creating reception boards highlighting the home their visions and values. During our visit, we saw this was also personalised with photographs of people and visitors involved in activities and events.

The service worked to develop links with the local community to benefit the people who lived there. People enjoyed their involvement with the schools nearby who visited the home for arranged events. The staff invited schoolchildren to come into the service to sing or participate in an activity with people. The registered manager also worked with local religious leaders, who visited to conduct religious services for people who wished to participate. A relative of a person at the service had also raised money for a sun house. This will allow residents to sit outside in the summer and enjoy outside entertainment. A further local fund raising community group had also donated their time to finish fencing around the outside of the service. They were painting it in bright colours for people at the service. The registered manager told us local charities had donated items such as solar lights for the garden pots and plants and one charity had donated presents at Christmas for people.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People's medicines were not always managed safely.</p> <p>The assessment of risks to people was inconsistent with some records lacking essential information to allow staff to manage people's care.</p>