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Brockhampton Court Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14, 19 and 20 June 2018. The first day of our inspection visit was unannounced.

Brockhampton Court Care Home with Nursing is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Brockhampton Court accommodates up to 58 people within a large adapted building, and specialises in care for older people and younger adults with physical disabilities. At the time of our inspection, 48 people were living at the nursing home.

The provider is also registered to operate a domiciliary care agency at this location. It provides personal care to people living in their own houses in the community and operates from a main office located within a separate building in the home's grounds. It provides a service to older people who may have physical disabilities . At the time of our inspection visit, 28 people were receiving care and support in their own homes from the agency.

Not everyone using the domiciliary care agency receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A registered manager was in post and present during 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 2008 and associated Regulations about how the service is run.

The provider's systems and procedures designed to ensure people received their medicines safely and as prescribed were not always as robust or effective as they needed to be, and did not always reflect current good practice. The provider had not adequately assessed the broader risks to people's health and safety and done all that was reasonably practice to mitigate these. The provider did not have formal systems in place for the clinical supervision of nurses or managerial supervision of care staff. People's care plans did not always fully demonstrate an individualised assessment of their care and support needs or fully support a person-centred approach to people's care. The provider had failed to notify us of eight serious injuries involving people who used the service, in line with their registration with CQC. The provider's quality assurance systems and processes were not as effective as they needed to be.

Staff received training in, and understood, their individual responsibility to protect people from abuse and discrimination. The staffing levels maintained ensured people's needs could be met safely at the nursing home, and that people received reliable and consistent care and support in their own homes. The provider completed checks on prospective staff to ensure they were safe to work with people. The provider had taken steps to protect people, staff and visitors from the risk of infection.

Staff completed the provider's induction and participated in a programme of ongoing training to help them work safely and effectively. Staff helped people to prepare their meals in their own homes, and offered physical assistance to enable people to eat and drink where they needed this. Any risks associated with people's eating and drinking were assessed and managed. Staff helped people to access healthcare services and played a positive role in ensuring their day-to-day health needs were met. The overall design and adaptation of the nursing home enabled staff to meet people's individual needs safely and effectively. Staff and management understood and promoted people's rights under the Mental Capacity Act 2005.

Staff approached their work with a kind and caring attitude and treated people with dignity and respect. People and their relatives were supported to express their opinions and be involved in decisions that affected them.

People had support to participate in a range of stimulating recreational activities. People and their relatives understood how to raise a complaint about the service, and had confidence they would be listened to. The provider had systems and procedures in place enabling them to identify and address people's preferences and choices for their end-of-life care .

The management team promoted a positive, open and inclusive culture within the service. Staff felt valued and well-supported in their work, and were clear what was expected of them. The management team promoted collaborative working with external health and social care providers to facilitate joined-up care for people, and had forged strong links with the local community.

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 handled and administered in line with good practice. The foreseeable risks to people had not always been assessed, recorded and plans implemented to manage these. Staff understood their individual responsibility to protect people from abuse and discrimination, and underwent pre-employment checks to ensure they were suitable to work with people.

Is the service effective?

Requires Improvement

The service was not always Effective.

The provider did not have formal systems in place for the supervision of nurses and care staff. The risks associated with people's eating and drinking had been assessed, recorded and managed. Staff and management helped people to access healthcare services.

Is the service caring?

Good

The service was Caring.

Staff adopted a kind and compassionate approach towards their work. People's involvement in decisions that affected them was encouraged by staff and management. People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

Care planning did not always fully reflect or facilitate a person-centred approach. People and their relatives were clear how to complain about the service. People's wishes and preferences for their end-of-life care were identified and recorded, in order that these could be met.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The provider had not notified us of a number of serious injuries to people who used the service in line with their registration with us. The provider's quality assurance was not as effective as it needed to be. Staff were clear what was expected of them and felt well-supported by the management team.

Brockhampton Court Care Home with Nursing

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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to an ongoing investigation by the local coroner and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls from bed. This inspection examined those risks.

The inspection took place on 14, 19 and 20 June 2018. The first day of the inspection visit was unannounced.

The inspection team consisted of two inspectors, an Expert by Experience and a specialist advisor who is a nurse specialist. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for their views on the service.

Over the course of our inspection visits, we spoke with 13 people who used the service, 10 relatives, the registered manager, the deputy manager, the manager of the provider's homecare service, the provider's training officer, the chef and two domestic staff. In addition, we spoke with two activities coordinators, three

nurses, five senior care staff and three care staff.

We looked at a range of documentation, including 13 people's care and assessment records, medicines records, incident and accident reports, seven staff recruitment records, staff training records, complaints records, selected policies and procedures, certification related to the safety of the premises and records associated with the provider's 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 people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in March 2016 we rated this key question as 'Good'. At this inspection, we found shortfalls in the safe handling and administration of people's medicines and the provider's broader approach to risk management. This key question is now rated as 'Requires Improvement'.

The provider had systems and procedures in place designed to ensure people received their medicines safely and as prescribed. However, these were not always as robust or effective as they needed to be. When starting work at Brockhampton Court, nurses and care staff received initial training in the home's procedures for the handling and administration of people's medicines.

However, refresher medication training was not organised for care staff, and checks were not carried out on the continuing competence of either nurses or care staff to administer people's medicines. The provider did not maintain accurate records of the quantity of each person's medicines carried over from the last medication cycle, preventing them for carrying out effective stock level checks on people's medicines. Stock level checks enable providers to, amongst other things, identify any discrepancies between the actual and expected stock balances of each person's medicines and confirm people are receiving their medicines as prescribed. We checked three people's prescribed medicines and found the expected and actual stock balances did not match. In addition, the stock levels of controlled drugs held on site were not always checked on a regular basis, in line with good practice.

'PRN protocols' had not always been implemented to provide nurses and care staff with clear guidance on when to administer people's 'when required' medicines. There was also a lack of consistent, clear guidance, and accurate record-keeping, in relation to the application of people's creams and ointments. The creams and ointments in use in the nursing home did not always have a prescriber's label attached to them detailing for whom they had been dispensed, and how and where they were to be applied. In addition, the dates these medicines were opened, and their calculated expiry date, had not been recorded on the medicines containers. Where people received support with their medicines in their own homes, the directions on their medication administration records (MAR) were not always sufficiently clear, increasing the risk of medication errors. Furthermore, people's MAR charts did always clarify the specific medicines administered by staff, referring to administration of the person's 'blister pack' with no accompanying information to state which medicines this contained. Handwritten entries on people's MAR charts had not always been signed by two trained members of staff in line with good practice.

Temperature records in the nursing home indicated the home's medicines refrigerator had been operating outside of the recommended temperature range for a 12-week period. This concern not been brought to the attention of the management team. Failure to store medicines within the recommended temperature range can affect their efficacy, stability and recommended shelf life. Where medicines do not require refrigeration, the temperature of the room in which they are stored should be regularly monitored to ensure it does not exceed the recommended limit of 25°C. We found the provider had no system in place for monitoring the temperature of the medicines room.

We discussed these concerns with the management team. They acknowledged the need for significant improvement in the management of people's medicines and assured us all of the issues shared with them would be addressed as a matter of priority. They took immediate action to address a number of these concerns during our inspection visits. This included the introduction of additional 'PRN protocols' and topical medication administration records, the commencement of staff medicines competency checks ,and steps to ensure the home's medicines refrigerator was operating within the recommended range.

Steps had been taken to assess, record and manage a number of specific risks associated with the individual care and support needs of the people living in the nursing home. Staff working in the nursing home and providing care and support to people in their own homes showed good insight into the risks to individuals. However, the provider's broader systems and procedures for assessing, recording and managing the foreseeable risks to people's health, safety and welfare were not as robust or effective as they needed to be. This included the failure to adequately assess the potential hazards to people within the physical environment of the nursing home. For example, the 'gallery area' on first floor of the nursing home provided unrestricted access to an external balcony surrounded by a low stone wall from which a steep metal staircase led to the home's garden below. Also located within the gallery area was a facility for making hot drinks and a steep unrestricted staircase leading up to the second floor of the home. None of these potential hazards had been subject to formal, recorded risk assessment in order to confirm appropriate measures were in place to minimise any associated risks to people and others. We discussed these issues with the registered manager who assured us they would conduct the necessary risk assessments. During our inspection visits, they took immediate steps to restrict access to the external balcony on the home's first floor, and external staircase leading down from this, based upon the risk assessment they completed.

A significant number of people living at the nursing home had bed rails fitted to their beds to reduce the risk of them falling out of bed. However, the provider did not have effective procedures in place for assessing and monitoring whether people's bed rails were correctly fitted, and whether bed rails protectors were required. The majority of bed rails we checked had been fitted too low, increasing the risk of people falling over the top of these. We discussed these issues with the registered manager. During our inspection visits, they introduced a more robust system for assessing and monitoring the use of bed rails within the nursing home. They also took immediate action to ensure the existing bed rails in use had been fitted safely and correctly.

Personal emergency evacuation plans (PEEPs) had not been developed for any of the people currently living in the nursing home in line with good practice. The purpose of the PEEP is to ensure the safety of the named individual in the event the building has to be evacuated. Procedures were in place to enable staff to record and report any accidents, incidents, unexplained injuries or 'near misses' involving people living in the nursing home or receiving care in their own homes. However, we were not assured unexplained injuries recorded on 'body maps' were always reviewed and investigated by the home's management team or nurses. Where people received care and support in their own homes, we found the risks associated with their individual care and support needs, and the agreed plans for managing these, had not been clearly recorded. This included risks associated with people's nutritional and hydration, the risk of falls, people's pressure care needs and the management of people's pain.

The provider had not adequately assessed the risks to people's health and safety and done all that was reasonably practice to mitigate these. This included a lack of effective systems and procedures to ensure the safe management of people's medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the care and support staff provided, both in people's own homes and

within the nursing home, helped people to stay safe. One person told us, "I'm looked after here [in the nursing home]… I feel safe." A relative explained, "When I leave [the nursing home], I know [person] is well looked after and as happy as they can be."

Staff received training in, and understood, their individual responsibility to protect people from any form of abuse or discrimination. They told they would immediately report any concerns of this nature to the management team. One staff member explained, "With abuse, I'm very confident management would take appropriate action and I would not hesitate to report matters."

Most of the people and relatives, and all of the staff, we spoke with felt the staffing levels maintained at the home ensured people's needs could be met safely. One person told us, "There are usually staff around; you can always shout for somebody … If you say you need help, you get it." During our inspection visits, we saw there were enough staff on duty to safely meet people's needs and respond to their requests for assistance without unreasonable delay. People who received care and support at home told us they received a consistent and reliable service from the provider. The provider had a call monitoring system in place to monitor this. A relative explained, "They [staff] always let me know when they are running late, which is never by more than 10 minutes or so."

The provider completed checks on prospective staff to ensure they were safe to work with people. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions.

The provider had taken steps to protect people, staff and visitors from the risk of infection. One relative told us, "They [staff] always have plenty of gloves and aprons and wear these when needed." During our inspection visit, we found the home to be clean, well-maintained and free from unpleasant odours. The provider employed domestic staff to support the nurses and care staff in ensuring the premises and equipment remained clean and hygienic. Staff had access to, and made use of, personal protective equipment, which comprised of disposable aprons and gloves. Suitable hand-washing facilities were available and hand sanitiser dispensers were sited at key locations throughout the home for use by staff and visitors. Where people received care and support in their own homes, the infection control practices of care staff was checked during monthly unannounced 'observations' conducted by the training officer.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in March 2016 we rated this key question as 'Good'. At this inspection, we found shortfalls in relation, for example, to the lack of formal supervision of nurses and care staff. This key question is now rated as 'Requires Improvement'.

Nurses and care staff told us they felt able to approach the management team at any time for informal support and advice. An on-call system was in place to enable staff to contact a named senior colleague or member of the management for guidance outside of office hours. However, the provider did not have formal systems in place in relation to clinical supervision of nurses or managerial supervision of care staff. Formal supervision has many benefits for staff, their managers and, most importantly, the people being supported by a service. Amongst other things, it provides an opportunity for staff to reflect on and review their practice, set performance objectives and identify any additional training and development needs. We discussed this issue with the management team who assured us they would implement formal systems of supervision for nurses and care staff as a matter of priority.

Before people moved into Brockhampton Court, or their care at home started, the management team met with them and their relatives to assess their individual care and support needs and develop individualised care plans. The management team recognised the need to avoid any form of discrimination in the planning or delivery of people's care. Staff and management liaised with a range of community health and social care professionals, including GPs, the community mental health team, occupational therapists, physiotherapists and specialist nurses, to promote positive outcomes for people and ensure they had access to the appropriate care equipment. One person described the benefits of the 'wheeled walker' they had been provided with, explaining, "It's an absolute miracle; it's made me mobile." However, we found the management team had not sought appropriate advice from the community tissue viability service and dietician in relation to the recommended management of person's pressure sore and recent weight loss. The deputy manager contacted the community tissue viability service in this regard during our inspection visits, and we were assured appropriate advice would be sought from the dietician as necessary.

People and their relatives felt staff had the knowledge and skills needed to meet people's individual care and support needs. One relative explained, "They [provider] are very careful and selective about who they employ, and that pays dividends as they have very competent and skilled staff." Upon starting work for the provider, all staff completed the provider's induction programme to help them understand and settle into their new roles. Staff spoke positively about their induction experience, which included the opportunity to work alongside, or 'shadow', more experienced staff and participate in initial training. The registered manager confirmed that the provider's induction programme took into account the requirements of the Care Certificate. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff.

Following induction, staff received a rolling programme of training, reflecting their duties and responsibilities, and people's care and support needs. However, this did not include refresher training on the handling and administration of people's medicines. The majority of staff spoke positively about their

training with the provider. One staff member told us, "I do feel I have had enough training for my role, and there is always someone on the phone for advice and guidance." Another staff member described the benefits of their first aid training, which had given them greater insight into cardiopulmonary resuscitation (CPR).

People and their relatives spoke positively about the quality of the food and drink served at the nursing home, and the support people had to prepare meals within their own homes. One person told us, "The food's very good really; practically everyone needs something different … Staff are aware of my problems … the chef is so good and does things specially for me" Staff supported people to choose between the options available for breakfast and the evening meal, and supplied people with drinks and snacks between meals. However, some people highlighted the lack of choice of food at lunch. We found alternative options were available for lunch, upon request, but that people were not actively reminded of these. The registered manager indicated they would review current procedures for promoting people's choice in what they ate for lunch.

We saw mealtimes were flexible, relaxed and social events, during which people chatted with one another and received physical assistance to eat safely and comfortably, where they required this. Any religious dietary requirements or specific risks associated with people's eating and drinking were assessed and recorded. Plans were in place to manage these, including the provision of texture-modified diets and adapted cutlery, and the monitoring of people's fluid intake. However, where people were provided with texture-modified diets, details of the associated specialist assessment completed by a qualified professional were not always readily available. We discussed this with the management team who assured us they would obtain details of the relevant assessments undertaken by nutritional specialists.

Staff and management played a positive role in ensuring people's day-to-day health needs were met, liaising with a range of community healthcare professionals. Where appropriate, the nurses carried out basic monthly observations to monitor people's health. Prognostic planning tools were used to track the progress of long-term health conditions, including Parkinson's disease, and anticipate people's health needs . People's care files included information about their medical history and long-term health conditions to ensure staff understood this aspect of their care needs. In the event of any significant deterioration in people's health, we saw staff helped them to seek urgent medical advice and treatment as required. A relative told us, "[Person] had an insect bite recently and they [staff] noticed it had become inflamed. They were very quick to get it looked at. [Person] also had a chest infection recently, which they spotted."

The overall design and adaptation of the premises enabled staff to meet people's individual needs safely and effectively. One relative told us, "I'm very, very pleased; it's a gold-medal environment." People had access to the home's extensive grounds, and suitable space within the nursing home to participate in social activities, dine in comfort, meet with visitors or spend time alone. The management team recognised the importance of adapting the physical environment of the nursing home to the needs of people living with dementia, and informed us they kept this under review. However, we found they lacked a clear strategy for creating a dementia-friendly environment. The registered manager assured they would carry out further research on this topic, and review this aspect of the environment on a more structured basis moving forward.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Staff and management understood people's rights under the MCA, and what this meant for their work with people. People and their relatives told us, and we saw, staff sought people's permission before carrying out their routine care and support. Do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decisions had been appropriately recorded in people's care files. Where people had appointed others to make decisions on their behalf, the management team had obtained proof of their lasting power of attorney (LPA).We saw evidence of people's consent to care in their care files. Individual mental capacity assessments and associated best-interests decisions had been completed in relation, for example, to people's pressure care and the administration of medicines. However, we saw contradictory information had been recorded in relation to people's capacity to consent to the use of bed rails. We discussed this with the registered manager, who assured us they would address this issue.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered manager had made applications for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, the registered manager had reviewed any associated conditions, in order to comply with these.

Good

Is the service caring?

Our findings

At our previous inspection in March 2016, we rated this key question as 'Good'. At this inspection, we found this key question remained 'Good'.

People and their relatives told us staff adopted a kind and caring attitude towards their work, and took the time to get to know people well as individuals. One person said, "You can't fault them [staff]. They are absolutely wonderful. They are so kind and helpful." They went on the describe how staff were gentle when carrying out their personal care, being mindful of their joint pain. A relative told us, "They [staff] are absolutely caring. They are very nice to [person] and are never brusque or rough with them." We saw people were at ease in the presence of staff, and readily approached them to engage them in conversation or to request support. Staff greeted people warmly, addressed them in a polite, professional manner and were attentive to their needs.

People and their relatives were satisfied with the support they had to express their opinions and be involved in decisions that affected them. They described an open, ongoing dialogue with staff and management. Staff understood the need to encourage people's involvement in decision-making about the care and support provided. One staff member explained, "As a matter of course, we consult families and residents about care and encourage them to speak up." We saw people's care plans included information about their individual communication needs. However, the guidance on how to promote effective communication with people was not always as clear or detailed as it needed to be and the provider's 'communication assessments' had not always been fully completed for all people. The registered manager assured us they would review these assessments and care plans to ensure staff had clear guidance on how to meet people's communication needs.

People and their relatives told us staff treated people with dignity and respect at all times. One relative said, "The staff are all 'rays of sunshine'. They never show impatience or frustration, and so I think that is how they show respect." People confirmed that staff recognised their need for, and actively promoted, their independence. On the subject of using their mobility aid, one person told us, "They [staff] encouraged me to do it and I can … We're encouraged to do whatever's possible." A staff member explained, "We encourage people to do as much as they can and promote independence all the time. We have adapted cutlery and plate guards to enable people to eat on their own."

During our inspection visits, we saw staff encouraging people to mobilise independently, in a patient and attentive manner. Staff met people's personal care needs in a sensitive and discreet manner. Staff received training to help them understand their individual responsibility to protect and promote people's rights to privacy and dignity. They gave us examples of how they did this on a day-to-day basis. This included knocking on people's bedroom doors before entering, protecting their modesty during personal care, and respecting people's wishes and choices.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2016 we rated this key question as 'Good'. At this inspection, we found shortfalls in relation to the standard of care planning and assessment of people's information and communication needs. This key question is now rated as 'Requires Improvement'.

Whilst staff knew the people they supported well, people's care plans did not always fully demonstrate an individualised assessment of their care and support needs, including consideration to characteristics protected under the Equality Act. For example, the nursing home was currently supporting two married couples. Although suitable arrangements were in place to provide each couple with privacy to live as a couple, and staff were aware of these, these living arrangements were not clearly explained in their care plans. Where people received care and support in their own homes, their care plans were particularly lacking in detail about the exact nature of their current needs, preferences and expressed wishes and how these were to be met through a consistent, person-centred approach.

This included a lack of clear guidance in relation to meeting people's communication and information needs in line with the Accessible Information Standard. The Accessible Information Standard tells organisation what they need to do make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. We discussed the Accessible Information Standard with the management team and found they lacked insight into its requirements.

The layout of people's care plans, and the manner in which these were reviewed, meant that it was not always straightforward to identify people's current needs. In addition, people's care plans sometimes contained contradictory information in relation, for example, to their dietary needs or capacity to consent to care. We found the language used in people's care plans was sometimes negative, referring to 'problem areas of care' as opposed to people's needs and strengths. For example, one person's risk assessment stated, "[Person] won't do anything for themselves; [they] won't even answer the phone."

We discussed the issues identified in relation to people's care plans with the management team. They acknowledged our concerns and, during our inspection visits, took steps towards introducing a new electronic care management system to address these. Following our inspection visits, the registered manager provided confirmation of the in-depth equality and diversity training arranged for staff, to enhance their understanding of how to work in a person-centred manner.

People and their relatives were satisfied with the extent to which staff and management involved them in assessment, care planning and day-to-day decision-making about the care and support provided. The majority felt the service provided reflected people's individual needs and preferences. One person described how staff accommodated the flexible daily routines of the people who lived at the nursing home. They told us, "If you want to stay in bed all day, you stay in bed all day; there's no set bedtime. I had a day off last week - a day in bed. We'd had such a lot going on and I was so tired." A relative whose family member received care and support in their own home explained, " [Person] is very, very particular, and they [staff] respect that.

[Person] is fastidious about their clothes, and they [staff] make sure they do everything the 'right' way. They have taken the time to get to know them." Another relative explained, "I think they [staff] are well chosen and they learn what you want – your ways and needs." During our inspection visits, we saw staff adapted their communication and the care and support provided to suit the individual.

People and their relatives spoke positively about the range of stimulating recreational activities on offer at the home, and the support people had to pursue their interests. One person spoke about their enjoyment of the home's gardening club, showing us the raised beds, pots and planters they and the other club members maintained. They told us, "They [staff] look after you mentally and physically; [they] keep your mind active … There's always something to do here." Another person said, "I'm very happy here … I like to be with people and I like walking [in the home's grounds]. I told my son, 'You've picked the right place.'" We saw people had access to a wide range of leisure and therapeutic activities, developed by the home's activities coordinators in response to people's requests, and their known interests and preferences. This included Zumba, Tai-chi and 'chair Yoga' classes, arts and craft sessions, group games and quizzes, and one-to-one time with one of the activities coordinators in people's rooms.

People and their relatives were clear how to raise a complaint about the service. They told us they would bring any complaints or concerns to the attention of the registered manager, and had confidence these would be satisfactorily resolved. One relative explained, "I have had no need to complain at all, but I know they [management team] would take a 'listen and learn' approach if I did; that is just how they operate." The provider had a complaints procedure in place to ensure complaints were dealt with fairly and consistently. We looked at the most recent complaint received by the service and saw it had been handled in line with this procedure.

The provider had systems and procedures in place to identify people's preferences and choices for their end-of-life care. We saw a number of people had been supported to make advance statements, setting down their preferences, wishes, beliefs and values regarding their future care. One person living at the nursing home was currently receiving palliative care, which was provided in line with their wishes. The management team used a monthly prospective prognostic planning tool to enable them, where appropriate, to chart an individual's deterioration and so anticipate their need for end-of-life care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in March 2016 we rated this key question as 'Good'. At this inspection, we found shortfalls in relation to the submission of statutory notifications to CQC and the effectiveness of the provider's quality assurance. This key question is now rated as 'Requires Improvement'.

During our inspection visits, we met with the registered manager who was responsible for the day-to-day management of the service. Although clearly experienced in and committed to their role, they lacked insight into the Accessible Information Standard and CQC registration requirements. Registered providers must, in accordance with their registration with CQC, notify us about certain changes, events and incidents that affect their service or the people who use it. These 'statutory notifications' play a key role in our ongoing monitoring of services. During our inspection visit, we became aware of eight serious injuries involving people who used the service, which the provider had failed to notify us of. They had, however, sought prompt emergency medical treatment and provided consistent nursing care in response to these events to support people's healing and recovery.

We discussed this issue with the registered manager, who acknowledged they had been unaware of the requirement to notify CQC of these events at the time they had occurred. They assured us they would fully review their regulatory responsibilities, in order to ensure all statutory notifications were submitted to CQC within the required timescales moving forward.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had not notified CQC without delay of incidents involved people who used the service in line with their registration with us.

The provider had quality assurance systems and processes in placed designed to enable them to assess, monitor and improve the quality of the care and support people received. These included 'service user meetings', care plans and medicines audits, the distribution of annual feedback surveys to people and their relatives, and the conducting of unannounced monthly 'observations' on staff supporting people in their homes. However, we were not assured that the provider's quality assurance was as effective as it needed to be. It had not enabled the provider to highlight and address the significant shortfalls in quality we identified during our inspection, including those relating to the management of people's medicines. The audits we looked at had not always been completed on a consistent basis, and did not always include details of the action taken to address any identified issues or concerns.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems and processes in place to enable them to assess, monitor and improve the quality and safety of the service.

Registered providers must display their current CQC rating in their main place of business and on their website. The purpose of this is to provide the people who use the service and the public with a clear statement about the quality and safety of the care provided. We found the provider's current CQC rating was

clearly displayed at the nursing home and on the provider's website.

The majority of people and their relatives spoke positively about the overall standard of the care and support provided, and their relationship with the management team. Along with staff, they described an open, transparent and inclusive culture within the service. One relative told us, "This is undoubtedly the best nursing home I've ever seen … When you get inside it's peace and tranquillity, which is very comforting." They went on to say, "I know I have access to [registered manager] and I respect her … I know she runs a tight ship. Everybody [staff] seems to be getting about their work. I know if I want something, I only have to ask." Another relative said, "[Manager of homecare service] mucks in and is wonderfully approachable."

Staff spoke enthusiastically about their work for the provider. One staff member told us, "I swore I would never work in a care home, but this place is fantastic." Another staff member said, "I think the home is good; I wouldn't be here otherwise … it doesn't feel like a business. It's people's home and provides a good quality of life." We saw nurses and care staff had good working relationships with the management team, and freely approached them for advice and support. Staff were clear what was expected of them at work, and felt valued and well supported by an approachable management team. One staff member explained, "I do feel valued and appreciated. The place is open and transparent and you are listened to by the manager." Another staff member said, "I think [registered manager] is good; [they are] firm and fair. I've never come away from talking to her thinking, 'I still don't get it.'"

Monthly general staff meetings and weekly senior staff meetings were organised to update and consult with staff as a group, and invite their ideas and suggestions. Staff told us they felt listened to by the provider. One staff member said, "I have complete confidence in the management team. I can speak my mind and we are listened to." The provider had a whistleblowing policy in place. Staff understood the role of whistleblowing, and felt able to challenge any practices or decisions taken by the provider which they disagreed with. One member of staff told us, "There is an open culture here. [Registered manager] will listen and act on anything raised. Staff would be encouraged to whistleblow."

The management team recognised the importance of, and promoted, collaborative working with external health and social care providers to facilitate joined-up care for the people they supported. For example, they produced 'care passports' for each person living at the nursing home to provide hospital staff with key information about their needs in the event of a hospital admission. Staff and management had forged strong links with the local community to the benefit of people living at the nursing home. This included connections with schools, churches, the theatre, a local football team, interest groups and charities.

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 Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC without delay of incidents involved people who used the service in line with their registration with us.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not adequately assessed the risks to people's health and safety and done all that was reasonably practice to mitigate these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to enable them to assess, monitor and improve the quality and safety of the service.