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Southdown Nursing Home

Inspection report

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Date of inspection visit:
09 January 2019
11 January 2019

Date of publication:
11 October 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 11 January 2019 and was unannounced.

At our previous inspection on 13 December 2017 we found the provider was in breach of the regulation in relation to good governance. The provider did not always act on concerns in a timely manner and some people told us there was not an open and transparent culture. We also found the service required improvement in several areas including medicines management, staffing, following best practice guidance in providing a suitable environment for people living with dementia, and person-centred care planning. At this inspection, we found the provider had made improvements in all of these areas but was still in breach of the regulation in relation to good governance because the provider's systems for identifying shortfalls in the quality and safety of the service were not robust enough.

Southdown Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 25 people in one adapted building. It provides personal care and nursing to older people, some of whom may be living with dementia. At the time of our inspection there were 21 people using the service. Because the service is operated by a sole provider who takes responsibility as the registered person for issues relating to the management of the home, Southdown Nursing Home is not currently required to have a registered manager.

Although the provider had made improvements to the safety of the service since our last inspection, we found at this inspection that the service was not always safe because there were no formal systems to ensure good hygiene and control the spread of infection, other than in the kitchen. The provider had not addressed a safety issue involving a broken floor tile and chemicals were not always stored securely. The provider did not obtain all of the information they are required to use when checking the staff they recruited were suitable to work at the home.

We found the provider was in breach of the regulation in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report. We are considering what action to take in regards to the continued breach of the regulation in relation to good governance and will report on this when it is complete.

The provider assessed risks to people on an individual basis. People had detailed risk management plans so staff knew how to keep them safe. These were designed to allow people as much freedom and choice as possible while ensuring they were safe from avoidable harm.

The provider had systems to ensure there were enough staff to care for people safely. People and their relatives felt the service was safe and there were robust procedures to safeguard people from abuse. Medicines were managed safely.

The provider could not always produce evidence that they complied with legal requirements about obtaining consent from people before providing care to them. Where people lacked capacity to consent, the provider could not always demonstrate that they had followed appropriate procedures to determine decisions were made in people's best interests.

People received care and support in line with national guidance. Staff received the training and support they needed to do their jobs effectively. People had access to healthcare services when they needed them and people's nutritional needs were met. The environment was adapted to meet people's needs, although some areas were in need of refurbishment.

People received care and support from staff who were friendly, respectful and caring. Staff made an effort to build good relationships with people and help them feel at home. Staff considered people's individual needs when providing information to them, so people understood and were able to make decisions about their care.

Staff were empathetic and gave people emotional support when they needed it. They respected people's privacy and dignity and promoted their independence by encouraging them to do as much for themselves as possible.

People had personalised care plans containing detailed information about what their care needs were, how they liked their care to be delivered and how staff should manage any healthcare conditions they had. People were involved in planning their care and the provider took into account people's wishes, preferences and diverse needs. There were systems to ensure information about people's changing needs was shared reliably amongst the staff team. Staff made sure people were comfortable when they reached the end of their lives and the home worked with relevant organisations to help ensure they provided end of life care in line with current best practice.

People took part in a variety of activities. This included trips out, visits from other organisations who provided activities, group activities planned by an activities coordinator and one-to-one time spent with staff. The provider established links with the wider community to help people feel involved.

People and their relatives knew how to complain and said they would feel confident doing so. The provider had a complaints procedure and systems to ensure they took appropriate action and identified any trends in complaints. People felt the home had an open and person centred culture where they were able to speak up about any concerns they had. The provider used a variety of tools to share information with people, their relatives and staff, to collect feedback and to plan changes and improvements to the service based on this feedback.

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

Some aspects of the service were not safe. There were no formal systems in place to prevent and contain the spread of infection. Chemicals were not stored securely. The provider did not always obtain all the information they needed to ensure the staff they recruited were suitable.

The provider had systems to ensure there were enough staff to care for people safely.

There were appropriate procedures to safeguard people from abuse. Individual risks to people's safety were assessed and managed.

Medicines were managed safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The provider did not always make sure they had evidence of people's consent before providing care to them.

Staff had the training and support they needed to care for people effectively. The provider sought appropriate guidance to help ensure they provided care in line with best practice recommendations. This included providing an environment that was suitably adapted for people using the service.

People received support to meet their nutrition, hydration and healthcare needs.

Is the service caring?

Good

The service was caring.

Staff were respectful and empathetic, giving people emotional support when they needed it and taking the time to build good relationships with them.

People had the information they needed to make decisions about their care, in a format that was appropriate for them.

Staff understood the need to promote people's privacy and dignity and supported people in ways that enabled them to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans that took into account their diverse needs, preferences and wishes about how they wanted their care delivered. The provider took steps to ensure people received appropriate care around the end of their lives.

People had access to a variety of activities inside and outside the home.

There was a complaints system and people knew how to use it.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The provider was not always proactive in identifying areas they needed to improve. This meant while they had made improvements in some areas, others had stayed the same or got worse.

However, the provider had made improvements to their governance systems and had plans for further improvements. They used audits to check several aspects of service quality and safety.

People, their relatives and staff had opportunities to feed back to the provider about their views of the service.

Southdown Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 9 and 11 January 2019 and was unannounced. It was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. We spoke with one commissioner and a social worker who worked alongside the service. We looked at previous inspection reports and notifications the provider is required to send to us about significant events that take place within the service.

During the inspection, we spoke with seven people who used the service, five relatives of people who used the service, the registered provider, the home manager and five members of staff including the chef and activities coordinator. We also spoke with a visiting healthcare professional. After the inspection we spoke with another healthcare professional who works with people using this service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2017 we found the service was not always safe because the provider did not have a formal system to ensure safe staffing levels were met and because the provider did not adhere to best practice guidance around protocols for medicines to be taken only when required. We also found some windows were not appropriately restricted.

At this inspection, people and their relatives told us they felt safe. They said, "I feel very safe here," "The staff are friendly and I feel [my relatives] are safe here" and, "I think [my relative] is much safer here than at home." We found the provider had taken action to address the shortfalls we identified at our last inspection. Window restrictors were in place. There were enough staff to care for people safely. Protocols were now in place for medicines to be taken only when required, to help ensure people received their medicines as prescribed. Since our last inspection, the provider had introduced a staffing needs assessment system they had developed using evidence from a study of nursing homes. The tool looked at the expertise of available staff as well as the needs of people using the service. The home manager told us they were planning to develop this further by using scores from a dependency tool to give a more accurate estimate of how much support each person would need. Although one person and one relative felt they would prefer more staff at weekends, most people we spoke with said there were enough staff to provide the care they needed. We observed that there were always staff present when people were using communal areas during our inspection.

Kitchen staff used cleaning checklists and appropriate food hygiene procedures to help prevent infection from spreading via cross-contamination or poor storage of food products. We also observed care staff using personal protective equipment such as disposable gloves at appropriate times to protect people from the risk of infection spreading. However, the provider did not have robust systems in place to ensure adequate standards of cleanliness and infection control in the rest of the home. Although the home employed a cleaner whom we observed cleaning the premises, there were no formal checks of cleanliness or infection control audits. We noted that two bathrooms had brown stains on baths and tiles and two toilets were visibly dirty.

Some aspects of the premises were not safe. Chemicals were not always stored securely in line with control of substances hazardous to health (COSHH) guidance. We found cleaning products including toilet cleaner and disinfectant stored on a shelf in a ground floor bathroom and a bottle of cleaning fluid left on the side of a bath in another communal bathroom, both of which were unlocked and easily accessible to people using the service. We also found bleach and other harmful chemicals in an unlocked basement cupboard. Although there were measures in place to prevent people from easily accessing the basement cupboard, it was not secure and we were able to open it without assistance from staff. There was therefore a risk that people could come to harm through contact with dangerous chemicals. We informed the registered provider, who moved the chemicals from the bathrooms and locked the basement door. We saw a poster indicating that there was a training session for staff about COSHH due to take place soon after our inspection, and the home manager confirmed several staff were booked to attend.

We noticed a broken floor tile in a downstairs toilet, which could have increased the risk of people tripping and falling. When we told the provider, they immediately made arrangements for the tile to be replaced, which was done by the end of our inspection.

Although the provider took immediate action to address the safety issues we identified, we did not find evidence that the provider had effective systems in place to ensure the home was safe. This was a breach of regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Other aspects of the environment were safe. Equipment was available for people with reduced mobility to use baths and showers safely and was checked and serviced in accordance with manufacturers' instructions. People and their relatives told us staff used equipment safely to support people to move between chairs and beds or to use toilets. There were arrangements in place to ensure water in bathrooms and bedroom sinks ran at safe temperatures. Equipment was available for staff to intervene in medical emergencies and the staff we spoke with knew how to use it. People also told us they knew how to use their call bells and staff came quickly when they did. The provider had introduced a robust system for analysing accidents and incidents, using a colour code to help them identify trends so they could take preventative action. This tool was linked with risk assessments to ensure risk management plans were updated where necessary following incidents.

The provider did not have all the information they are required to obtain from new staff during the recruitment process. Four of the six staff whose files we checked had not supplied a full employment history including dates, because the provider did not ask for this on their application form. Care providers are required to check employment history for all staff so they can check there is a satisfactory explanation for any gaps in employment. This gives the provider assurance that staff are of good character and suitable to work in social care.

People had individual risk assessments, which made it clear what the risks were and what the consequences might be if the service failed to address them adequately. This included risks in relation to choking, malnutrition and falls. Staff had clear instructions about how to manage the risks. Where people were at risk of developing pressure ulcers, the provider took appropriate measures to reduce the risk. In cases where people had pressure ulcers or wounds that were deteriorating, staff took immediate action to reduce the risk to people. This included an ongoing wound treatment plan and close monitoring. Staff discussed this and other potential risks to people at handover to ensure they had the information they needed to protect people from known risks. Staff also discussed people's risks with them, and we noted in one case a person had signed a waiver to say they did not want to receive support in accordance with one of their risk management plans and that they understood and accepted the risks involved. The provider had carefully considered beforehand whether this arrangement would be likely to cause the person to come to serious harm and had concluded that it would not. This showed people had choices in how their risks were managed and the provider worked to keep people safe in the least restrictive ways possible.

There were systems in place to safeguard people from abuse. Staff were trained in safeguarding and there was a clear procedure to follow if any abuse was alleged or suspected. We saw where the provider documented any allegations of abuse, carried out investigations and reported allegations to the local authority safeguarding team.

People told us, "I get my [medicine] at the same time every day" and "I get my medicines on time." Medicines were managed safely. They were stored securely in a locked cabinet. There were systems in place to check stocks of medicines, including liquids and inhalers, and to ensure medicines were not being mislaid or taken without authorisation. Records indicated that people received their medicines as prescribed,

including topical medicines. Where people were prescribed medicines with variable doses, such as warfarin, the home had systems to ensure people received the correct dose and the amount in stock could be checked accurately. Staff who administered medicines were qualified nurses who had regular training and competency assessments.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2017 we found the service was not always effective because the provider did not always follow best practice recommendations about this type of service. We recommended the provider reviewed their practice in line with good practice guidance regarding the safe management of medicines and providing a dementia-friendly environment. At this inspection we found that the provider had made improvements in this area. For example, there was dementia-friendly signage throughout the home to help people find their way around. The home manager told us there had been a noticeable improvement in people's confidence and ability to navigate the building since the signs went up.

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. Appropriate processes were not always being followed in regards to MCA (Mental Capacity Act) assessments and best interest meetings. For example, staff told us one person had capacity to consent, but we found the consent forms in their file had been signed by a family member. The home manager told us they had originally thought the person did not have capacity, but there was no evidence of any formal assessments of mental capacity being carried out. The MCA Code of Practice states that providers should assume people have capacity unless there is evidence that they do not. This is to reduce the risk that people are denied their right to decide whether or not they want to have the proposed care and treatment. There was no evidence that the person had had the opportunity to consent, and they may therefore have been receiving care against their wishes.

The same person also had potentially restrictive bed rails in place, but there was no evidence that the person had consented to having these. When we queried this with the home manager, they told us the person's relative had said they should have bed rails, but they had not checked the person consented to having them or that it was in the person's best interests. The manager told us they would review this as soon as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Several people who used the service had DoLS authorisations in place. We checked whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

People told us, "The staff seem to know what they are doing" and, "As far as I know the staff are well trained." Staff had access to the training and support they needed to carry out their roles effectively. We saw evidence that staff received an annual appraisal and had regular meetings with their line managers to discuss their work. Training included courses about specific health conditions people using the service had, such as diabetes and dementia. The provider had introduced the Care Certificate, a qualification designed

to provide a basic knowledge of social care and good practice, and most staff had completed or almost completed the certificate.

People received care and support in line with professional guidance. We saw one person using exercise equipment recommended by a healthcare professional. Care plans were based on advice and guidance from healthcare providers and other professionals involved in people's care where relevant. This included speech and language therapists, physiotherapists and falls prevention team. People told us, "I do get visits from the doctor" and, "I do get to see the doctor and the optician." Records confirmed people had regular contact with healthcare professionals to meet their day to day health needs. There was detailed and personalised information for staff about how to maintain people's health and wellbeing and how to recognise when people were becoming unwell and required intervention from healthcare services.

Some parts of the home were in need of refurbishment. However, the provider was aware of this and there was evidence that they had plans to make improvements within the next year including replacing furniture and adding sensory features to the garden. We will check the provider's progress with this at our next inspection.

The environment was otherwise suitably adapted to meet people's needs. Communal areas were wheelchair accessible and people had a choice of areas where they could spend time during the day. A corner of the communal living space was decorated to reflect the favourite football team of two residents and people had personalised their bedrooms with photographs and personal items.

We received positive feedback from people and relatives about the food provided at the home. One person said, "The food is quite nice. There are a couple of choices and a choice of pudding." A relative told us, "The food is very good, just like home cooked food." We spoke with the chef, who told us all meals were prepared from scratch and they were able to offer alternative choices to anyone who did not want what was on the menu. The home had a four-weekly menu with a variety of healthy meals appropriate to the cultural background of most people using the service. The chef was aware of people's individual dietary needs, such as those with diabetes or a high risk of choking. We sampled the food that people were offered for their main meal and found it was well cooked and of high quality. Care plans covered people's individual nutritional needs and staff monitored people's weight and dietary intake, referring them to appropriate healthcare services if they had significant weight changes. Where people needed support to eat or drink, there were detailed instructions in their care plans to help ensure staff provided people with the correct support. We saw staff supporting one person to drink from an adapted cup and another person using adapted cutlery to eat independently.

Good

Is the service caring?

Our findings

At our last inspection in December 2017, we found that the service required improvement in this key question because information was not available in accessible formats, meaning people who were unable to read or understand complex information might not have the information they needed to make decisions about their care. At this inspection, we found the provider had addressed this. Information was displayed in accessible formats, for example a large electronic screen in the foyer with photographs of the main meal options. Care plans included information about people's specific communication needs. This included how staff should enable people who found it difficult to communicate to express themselves. Care plans took into account that people were likely to feel frustrated and upset if staff failed to communicate with them in ways they understood. This awareness helped people feel valued and listened to and also helped ensure people had access to the information they needed about their care.

People told us, "The home has very caring staff. I'm happy here" and, "It's a friendly place because of the atmosphere and the people to talk to." Relatives told us, "The minute I came here I knew it was the right place for my [relative]. The care they give is wonderful" and, "The carers are very kind." A visiting healthcare professional told us staff, including the home manager, knew people well and had good relationships with them. It was clear from our observations that staff had taken time to get to know people well and develop positive caring relationships. They used communication styles appropriate for each person's level of understanding and they initiated conversations about people's loved ones and other things that were important to people. Throughout the inspection we observed a friendly, relaxed atmosphere with staff joking and singing with people spontaneously. On one occasion a member of staff was trying to remember the words of a song and encouraged people to join in to help them, which several people did and clearly enjoyed themselves.

People received emotional support when they needed it. We observed one person who was visibly upset and asking to see the manager. The provider spoke to the person in a comforting and sympathetic way, said they would arrange for the manager to meet them when they came in and offered the person a private space to talk if they did not want to wait for the manager. People's care plans included information about how to support them when talking about difficult subjects. For example, people living with dementia may sometimes be unaware due to memory impairments that their loved ones have passed away. We saw one care plan with information about how staff should support the person if they asked to see their deceased relatives in order to minimise their distress.

Staff understood how to promote people's privacy and dignity. Care plans took into account people's need for privacy and were designed to help staff support people in the least intrusive ways possible, for example while supporting people with intimate personal care. One example we saw was a person who had been assessed as needing one-to-one support due to risk. The member of staff supporting the person observed them while giving them as much space as possible so the person did not feel their personal space was being invaded. A relative told us, "When they move [my relative using equipment], they always do it so professionally and in such a caring way." Relatives told us they felt welcome at the home.

Staff supported people in such a way as to promote people's independence as much as possible. For instance, one person was able to use a toaster in their bedroom because the risk of them coming to harm had been assessed appropriately and there was a risk management plan in place. We observed staff supporting people to do tasks they found challenging, but rather than doing things on people's behalf the staff provided them with verbal support and encouragement so they could do as much as possible for themselves. This provided people with meaningful engagement and helped people avoid losing skills.

Good

Is the service responsive?

Our findings

At our last inspection in December 2017 we found the service was not always responsive. Some care plans lacked detail around the specific interventions people required around behaviour that challenged the service, conditions such as epilepsy or people's preferences about how they wanted their care delivered.

At this inspection, we found the provider had made improvements. People and their relatives told us the service provided personalised care. One person told us, "The care is excellent here." Another person said, "They seem to know what they are doing. I need help for my bath." People's care plans had been reviewed and now contained more personalised information about the care and support they needed. This included information about specific conditions and the support people needed to manage their symptoms, use of mobility equipment, prevention of pressure ulcers, how to support people to manage continence needs and support people required to complete personal care tasks. For one person, there was information about the use of a routine to help reduce stress and anxiety.

People who had complex conditions such as epilepsy or diabetes had care plans with personalised information about how the condition affected the person and how to meet their individual needs around it, such as managing their symptoms. Care plans also contained information about any equipment people required to meet their care needs and how it should be used. Staff also used a handover system to note on each shift what people's main needs were currently. This included care for anyone who had pressure ulcers or wounds, appointments or increased care needs due to illness. There were notes about each person's general wellbeing and whether they had been involved in any accidents or incidents. This detailed information helped to ensure people received their care in a consistent manner from staff who were well informed about their needs.

People were involved in planning their care, as care plans considered people's wishes and preferences throughout. Relatives also told us they were involved in the process. One person had written parts of their own care plan by hand and staff had typed it out afterwards so it was more legible. Care plans instructed staff to check people's preferences whenever they provided care. Where necessary, consideration was given to finding a balance between what people wanted and what they needed to meet their care needs safely. Care plans took into account people's diverse needs, for example around sexuality, disabilities or religion.

At our last inspection, some people felt there were not enough opportunities for trips out. At this inspection people told us they enjoyed activities at the home. One person said, "I like the exercise sessions and keep fit, which they do twice a week." We discussed with the home manager how they protected people from the risk of social isolation, particularly those who generally remained in their bedrooms during the day. This included encouraging people to come to communal areas if they were able to join group activities, but if they did not wish to do so staff ensured they checked regularly that people were comfortable. At the time of our inspection the provider had been looking at ways of improving engagement and stimulation for people. The home had a weekly diary of events and activities, which was on display in communal areas so people knew what was happening. We observed group activities taking place including Zumba and dominoes, where there was a lively atmosphere and people appeared to be enjoying themselves. The provider

arranged for music therapists from the local clinical health team to lead innovative mindfulness sessions designed for people with dementia and learning disabilities. These sessions involved live music alongside adapted mindfulness techniques and a colouring activity. Other activities the home had introduced since our last inspection included visits to a local tennis club, musical shows and pantomimes and a visit from an organisation called Zoolab, which provided animal therapy and hands-on learning about unusual animals.

When compiling people's care plans, staff gathered information about people's favourite activities, life history and what was important to them. We saw one person drawing and painting throughout the inspection. The person told us, "I get support to do the things I want to do" and some of their artwork was on display. The home had an activities coordinator, who asked people weekly what activities they would like planned and was in the home leading activities during our visit.

Some people had care plans to address their changing needs as they approached the end of their lives, although others did not. The home manager told us this was a work in progress and they had meetings planned with people and their relatives to discuss this aspect of their care if they did not yet have end of life care plans. The manager acknowledged that this was a difficult subject to raise with families and told us they had been engaging with local services to develop their expertise in this area. We saw evidence that they had introduced the idea of end of life care plans at residents' and relatives' meetings and in newsletters. We also saw some examples of work that the service had done to ensure people received good care at the end of their lives, including special training for staff, informal discussions with staff to ensure they understood people's needs and finding out from people and their families what was important for them to have at this time. The home worked closely with a local hospital specialising in cancer treatment and palliative care. We heard about one of the music therapists who often visited staying at the home overnight to play soothing harp music for a person who was approaching the end of their life. Staff had made an effort to ensure the person's last few hours were as comfortable and dignified as possible and provided them with calming lights and scents alongside the music.

People and their relatives told us they knew how to make complaints, although nobody we spoke with had needed to do so. The provider kept a log of informal complaints and concerns people and their relatives raised. They documented their responses to these, including changes they made and in one case a letter written to the person who had raised a concern, telling them what they had done in response. The provider had carried out an analysis of complaints and concerns to determine whether there were any themes they needed to address. We saw that no particular concerns arose from this.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2017 we gave the home a rating of 'requires improvement' in the key question, 'Is the service well-led?' This was because the provider's governance system was not robust enough to proactively identify shortfalls in the quality of the service. The service has remained 'requires improvement' in this key question since we introduced our current ratings system, with comprehensive inspections in November 2016, November 2015 and April 2015. Although the provider has taken action to address problems on each occasion where we have identified them, the lack of a robust governance structure has led to us finding different problems at each inspection as the provider has failed to take proactive action to prevent, identify and address them.

We discussed this with the provider and home manager, who demonstrated improvements they had made to the quality assurance system. This included an 'audit of audits' to ensure they did not miss any of the checks they were required to make. The provider had also appointed 'champions' who were members of staff with extra training who took responsibility for ensuring good practice in particular areas such as end of life care or supporting people living with dementia. The home manager had undertaken a number of training courses to develop their knowledge and skills as a nursing home manager. The provider told us that although their current registration does not require them to employ a registered manager, they planned to apply for registration for the home manager in the near future to add an extra level of responsibility and oversight. The home manager told us they believed this would help them clarify lines of accountability and improve the structure and processes within their governance system. We saw evidence of some of the work they had done to improve processes and make them more effective, for example for wound care. An external professional told us they felt the home had made significant improvements over the last year. They told us, "Gaps in terms of the quality of nursing care and in leadership and have been filled. The management are more aware of responsibilities and have more concrete plans for improvement."

However, we found that although the provider had made improvements to the service and resolved the issues we found at our last inspection, we were still finding new problems that were not apparent at previous inspections. This shows the provider's governance system was still not as robust as it should be and this has been the case at each of our previous inspections against the current regulations. This is the sixth inspection since November 2015 at which we have judged the provider to be in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014 due to shortfalls in the provider's quality assurance and governance systems. In April 2015 we found the provider was in breach of seven regulations. In November 2015 the provider's quality assurance systems had failed to identify shortfalls in the quality of medicines management and treating people with dignity and respect. We also found a continuing breach of the regulation relating to person-centred care from our April 2015 inspection. In May 2016 we found the provider was again in breach of regulation 17 because their governance system had failed to identify problems with medicines management and did not have systems in place to ensure they submitted the required statutory notifications to CQC. We served the provider with a warning notice. In November 2016, we found care records were not always complete and accurate, including some information missing about medicines people were prescribed and the provider was also judged to be in breach of regulation 17. We followed this up with a focused inspection in March 2017, after which we served the provider with a warning

notice for a continued breach of regulation 17. We found similar issues with records in December 2017 at which point the provider was again in breach of regulation 17.

At this inspection, problems the provider's governance systems had failed to identify included information missing from staff recruitment records, a lack of cleanliness and infection control monitoring, unsafe storage of cleaning chemicals and a lack of clear and complete records to demonstrate the provider was complying with legislation around consent to care. These included documents that misleadingly suggested relatives were responsible for consenting on people's behalf and a lack of records of the consent people had given for the care they were receiving.

We also found the provider was still not always proactive in addressing concerns. For instance, when we found cleaning chemicals were left in communal areas at this inspection the provider immediately arranged for them to be removed, but we noted that their checks of the premises had failed to identify this problem beforehand. We did not see evidence that the provider checked any of these things in the audits or action plans they had carried out since our last inspection.

Although we found significant improvements had been made since our previous inspections, the provider was still in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Other than in the areas identified above, we found evidence that the provider had carried out several audits and checks since our last inspection. These included quality of care plans, medicines management, data protection and analyses of complaints and concerns, accidents and incidents.

The provider established links with the local community to enrich people's lives and help to make people feel involved in their community. This included working with an organisation that supported people to go on outings. Staff told us local people with learning disabilities were invited to come to the home and join the weekly "musical mandala" activity sessions, which had been a success. An external healthcare professional told us the home manager was "very supportive of [our service]" and "prepared to go the extra mile to learn new ways of reaching out to people." Another healthcare professional told us the service was good at working with other providers and communicated well.

People told us the home had an open and person centred culture. One person said, "The management team are very friendly and approachable." A relative told us, "I speak to the manager from time to time. Everyone is very polite." An external healthcare professional told us management was much more visible than it had been in the past and the home manager was very good at working with people and their families. After a previous inspection identified that some people did not feel the management team were approachable, the home manager used a variety of methods to facilitate open communication with people, their relatives and staff. This included use of a messaging app for staff to share information about any concerns, rotas and handover information.

The home manager regularly reminded people and relatives how to contact them and was open about sharing information such as their previous inspection report and ratings. They also checked regularly via surveys that people, relatives and staff felt comfortable expressing their views to management. During the inspection we saw several people and staff approaching the manager to discuss their care. We noticed the home had a very relaxed and friendly atmosphere, which people and their relatives told us was because the provider and manager worked hard to make people feel comfortable and at home. An external healthcare professional told us the manager was good at promoting a relaxed and homely space for people amid the "sometimes chaotic" nature of nursing care. The home manager told us they had recently qualified as a yoga teacher and were planning to bring their skills to the home to support staff. They had also signed up to

participate in a leadership programme designed to support managers of this type of service to develop their leadership skills and improve the quality of their service.

Since our last inspection the provider had introduced a new system for gathering the views of people and their relatives and making sure they acted on any suggestions or requests. There was a meeting every three months for people and their relatives to discuss news and events around the home, offer suggestions and raise any concerns they had. The provider then produced a newsletter summarising the discussions and action they were planning to take in response to people's suggestions and concerns. They then carried out a survey every three months to check whether people and their relatives were happy with changes made as a result. This meant people had an opportunity every six to seven weeks to feed back their views in a structured way. Newsletters contained information such as how the home celebrated the lives of people who passed away, the new dementia-friendly signage, changes made to the menu, activities, refurbishment of the home and the complaints procedure.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not provide care and treatment in a safe way for service users. This included ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way and assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (1)(2)(d)(h)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not effectively operate systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

We served a warning notice against the provider.