

HC-One Oval Limited

Oakhill House Care Home

Inspection report

Eady Close
Horsham
West Sussex
RH13 5NA

Tel: 01403260801

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service:

Oakhill House Care Home is registered to provide nursing care and support to a maximum of 49 people. 26 people were living at the service at the time of our inspection. The service is intended for older people, who may be living with a physical disability or dementia.

People's experience of using this service:

People told us and we observed that they were safe and well cared for and their independence was encouraged and maintained. Comments included, "This is a good place to live, I feel safe."

- The service had made improvements since our last inspection. This meant people's outcomes had improved. However, whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. For example, an external Legionella and Water Safety Risk Assessment in December 2018 had made recommendations that required action within a certain time frame. There was no improvement plan relating to the work and the water checks on the empty floor were irregular.
- People's safety was not always protected. The security of the building needed to be reviewed, to ensure people could not enter unannounced.
- The lack of opportunity to provide meaningful activities was known but not yet acted on, or a plan put in place to address this.
- These were areas that required further improvement.

We have made a recommendation about seeking expert advice about the administration and use of medicines given covertly (disguised in food/drink).

We have made a recommendation about seeking expert guidance regarding oral hygiene practices.

- People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was safe.
- People's health risks were assessed and strategies put in place to mitigate the risks.
- Staff received improved supervision and training since our last inspection, which provided them with the knowledge and skills to perform the roles they were employed to do.
- People received their care and support from a staff team, who had a full understanding of people's care needs and the skills and knowledge to meet them.
- Staff were given an induction when they started and had access to a range of training to provide them with the level of skills and knowledge to deliver care efficiently.
- People and relatives provided consistently positive feedback about the care, staff and management. They said the service was safe, caring and well-led.
- Staff treated people with respect and kindness at all times and were passionate about providing a quality service that was person centred.

- People's care was more person-centred. Care delivery was designed to ensure people's independence was encouraged and maintained.
- People were involved in their care planning.
- There was a happy workplace culture and staff we spoke with provided positive feedback.

The service met the characteristics for a rating of Requires Improvement.

More information is in our full report.

Rating at last inspection: Requires Improvement. (Report published on 6 November 2018.)

This is the second time the service has been Requires Improvement. However, improvements were seen and there were no breaches of regulation.

Why we inspected:

- As part of our enforcement action following our prior inspection, we served a warning notice and this inspection was scheduled to look at their action plan and ensure improvements had been made.
- All services rated as 'Requires improvement' are re-inspected within one year of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received and the improvements made.

Follow up:

- We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective

Details are in our Effective findings below.

Good ●

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Oakhill House Care Home

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

The inspection team consisted of two inspectors.

The service is required to have a registered manager:

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The service type:

Oakhill House Care 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. Oakhill House Care Home can accommodate up to 49 people in one building. Only the ground floor was currently being used at this time.

Notice of inspection:

We did not give the provider any notice of this inspection.

What we did:

Before the inspection we reviewed the information we held about the service and the service provider, including the previous inspection report. We looked at the action plan provided following the previous inspection and the response to the warning issued in October 2018. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with:

- 11 people and observed care and support given to people in the dining room and lounges
- Four people's relatives/visitors.
- Nine members of staff
- Three external healthcare professionals.

We also reviewed the following documents:

- Six people's care records
- Records of accidents, incidents and complaints
- Four staff recruitment files and training records
- Audits, quality assurance reports and maintenance records

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At the last inspection on the 11 and 14 May 2018, we asked the provider to take action to make improvements to the deployment of staff and this action has been completed.

Assessing risk, safety monitoring and management:

- The security of the premises had not assured that people and staff were adequately protected from unwelcome visitors. On our arrival, the electronic front door opened and allowed entry to the service. There were no staff present and the bell on the reception desk was not answered. After 15 minutes waiting, we left the entrance and entered the service unchallenged to search for staff. Staff told us the doors were opened at 8 am, but the receptionist did not arrive until 9-9:30 am. A risk assessment regarding the front door being open had not been undertaken. This practice was immediately reviewed by senior staff who acknowledged the security issue. We were informed the door would, in future remain closed until a staff member was available to ensure no unknown persons entered the premises. As immediate action was taken, the risk was reduced and managed.
 - No record was found relating to the maintenance and cleaning of wheelchairs. Following the inspection visit, the registered manager confirmed checks were undertaken but had not been recorded. This had not assured the equipment was fit for use.
 - The service had a portable suction machine that was to be used in emergency situations if a person was choking. However, there was no evidence of maintenance checks and therefore it was not fit for purpose. The deputy manager was not aware of checks being carried out.
 - Despite pressure mattresses for those people on bedrest being checked two hourly, one mattress was found fully deflated, which had not been identified by staff providing care. This was immediately brought to the staff's attention and action was taken and the risk of pressure damage was reduced.
- These were areas that required improvement.

- People's individual risk assessments were detailed and were updated regularly. These plans set out the risks and control measures to mitigate the risks. For example, people with mobility problems had an assessment that was used to give clear guidance for staff to follow. This included the specific equipment to be used, such as walking frames and electrical hoists.
- Equipment, such as electrical hoists and pressure mattresses had been serviced regularly as per the manufacturer's guidance.
- There were detailed fire risk assessments, which covered all areas in the home. Staff confirmed they had had fire training. People had Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported in the event of a fire. These were specific to people and their needs.
- Premises risk assessments and health and safety assessments continued to be reviewed on an annual basis, this included gas, electrical safety and fire equipment. The risk assessments also included

contingency plans in the event of a major incident such as fire, power loss or flood.

Using medicines safely:

- People did not have any concerns regarding their medicines. One person said, "I get my pills on time," and, "I trust them and they have not let me down at all."
- Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as required. We saw medicines remained stored securely. Medicines were supplied to the home in a monitored dosage system (MDS). Systems ensured all medicines were disposed of safely.
- All staff who administered medicines had the relevant training and competency checks. Nursing assistants had received support and training to ensure confidence in their extended role.
- There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included recording the effectiveness of the medicine.
- People who received covert medicines (Covert administration is when medicines are administered in a disguised format) did not all have clear directives in place that ensured staff offered medicines in a normal way before giving them covertly.

We recommend that advice is sought from allied health professionals in respect of the administration and use of medicines given covertly in line with the National Institute for Health and Care Excellence (NICE) guidance.

Safeguarding systems and processes:

- People were protected from the risks of abuse and harm. Since the last inspection improvements to the management of safeguarding investigations had been made. There was a safeguarding folder that contained the referral and investigation document. It also contained the outcome of the investigation with action plans where required. Feedback from the local authority included, "The management team have worked hard to make improvements and work very well with us."
- Oakhill House Care Home had followed safeguarding procedures, made referrals to their local authority, as well as notifying the Care Quality Commission in a timely way'.
- People told us they felt safe living at Oakhill House Care Home. One person said, "I feel safe living here." Another resident said, "I'm safe here, they look after us well." A visitor said, "I have no concerns, very pleased with everything."
- There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority.
- Staff continued to have a good understanding of their responsibilities and how to safeguard people. A staff member said, "We have had training, really good training, and if we have any worries we can go to the manager or the deputy." Another staff member said, "The training is invaluable, it's a big responsibility keeping people safe."
- Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The provider had an equalities statement prominently displayed in the entrance of the home, which recognised their commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Staffing and recruitment:

- This inspection found that staff deployment had ensured people's needs were met in a timely manner and in a way that met their preferences. Care delivery was supported by records which evidenced that people's needs were met. Food and fluid charts were completed in real time as were turning charts and continence records. This meant staff could monitor and ensure people's needs were consistently met.

- 26 people currently lived at Oakhill House Care home with a range of differing needs and the majority of people also lived with dementia. The provider used an organisational dependency tool to calculate staffing levels. Staff told us that there were enough staff to do their job safely and well. People told us, "I have never had to wait for help, always helpful," and, "I have no worries about staffing." A visitor told us, "I think they are using a lot of agency but it's not been a problem, because they are regular faces."
- We looked at four staff personnel files and there was evidence of continuing robust recruitment procedures. All potential staff were required to complete an application form and attend an interview so their knowledge, skills and values could be assessed.
- The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Preventing and controlling infection:

- Oakhill House Care Home was adequately maintained, clean and free from odour.
- Staff continued to have access to personal protective equipment (PPE) such as disposable gloves and aprons.
- Staff confirmed they had received training in infection control measures. Staff could tell us of how they managed infection control and were knowledgeable about the in-house policies and procedures that govern the service.

Learning lessons when things go wrong:

- Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents were escalated to other organisations such as the Local Authority and CQC.
- Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. For example, one person had had an unwitnessed fall in their bedroom. Staff looked at the circumstances and ensured that risks such as footwear and trip hazards were explored. A mattress had been placed by their bed. This meant staff could support the person safely.
- Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

At the last inspection on the 11 and 14 May 2018, we asked the provider to take action to make improvements to the meal service provision and this action has been completed.

Supporting people to eat and drink enough to maintain a balanced diet:

- People who needed assistance were supported once everybody had been served. This had ensured people were not rushed or left with their meal in front of them. A new chef had just started employment with the service and was on their induction.
- People's food preferences were considered when menus were planned. Comments from people included, "Good food, has improved lately," "They offer us a choice and we can have something different if I don't want what's on the menu." Visitors told us, "Very good variety, always nicely presented." People were shown the meal choices by staff as the meal service began, which meant that they could visually make their choice.
- There were appropriate risk assessments and care plans for nutrition and hydration.
- Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) had been made when necessary.
- People had correctly modified texture diets and fluids where there were risks of choking. All meals were attractively presented and staff promoted independence with the provision of angled cutlery and plate guards.
- The home manager had a 'tracker' which noted people's weights and malnutrition scores. These could be traced over time to check whether there were any risks and flag staff to request a dietitian's input.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- We saw staff continued to apply best practice principles, which led to effective outcomes for people and supported a good quality of life.
- People had pre-admission assessments before they moved into Oakhill House Care Home. This meant the service and staff could cater for people's care needs. This meant the service and staff could cater for people's care needs. We saw professionals' involvement in these assessments, including social workers and GP's.
- Oakhill House Care Home continued to meet people and arranged trial periods to manage people's needs and assess risk prior to their admission. One person told us, "I did visit before moving in." Another person said, "I think I chose to stay here."
- Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practices, which contributed to good outcomes for people.
- People's needs continued to be comprehensively assessed and regularly reviewed. Care plan reviews took place at least monthly, or as and when required.
- People's past life histories and background information were also recorded in the care documentation.

- People continued to be involved in their care planning and the people we spoke with confirmed this. We asked people if they were involved in planning their move to the service, one person told us, "I was involved with all the decisions." A visitor said, "The staff came to visit my mother to ensure that they could care for her."

Staff support: induction, training, skills and experience:

- People told us staff were competent. One person said, "Staff know how to look after us." A second person told us, "Staff know exactly what I need."
- The provider provided staff with regular training to ensure they had the right knowledge and skills to carry out their roles. Staff told us that they completed essential training such as infection control, moving and handling and safeguarding. They also confirmed that they had specific training such as understanding dementia, catheter care and equality and diversity. The training records confirmed that 90% of training had been completed.
- Staff spoke positively about the training sessions they had received. One staff member told us, "I feel I get the right amount of training including refresher courses via [organisation name] and its usually done on protected time."
- The registered manager and records confirmed staff supervision had been behind but was now being undertaken regularly and staff told us they felt supported. Comments included, "We have had changes and it's been a journey, but I do feel supported through the changes," and, "I have had supervision and it's always helpful to be able to discuss things."

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:

- Oakhill House Care Home continued to ensure joined up working with other agencies and professionals to ensure people received effective care. We saw people continue to have multi-disciplinary team meetings to discuss people's needs and wishes.
- The service continued to have links with other organisations to access services, such as tissue viability services and speech and language therapists (SaLT).
- A range of multi-disciplinary professionals and services continued to be involved in assessing, planning, implementing and evaluating people's care, treatment and needs. This was clear from the care planning documentation and the professional visiting logs. A visiting healthcare professional told us, "Staff have always been polite and knowledgeable about their residents and they are quick to refer to us when necessary. This really helps us to be able to provide effective treatment."
- People were assisted with access to appointments. People told us, "If I have to go to the hospital, someone comes with me," and, "If I need an urgent appointment, staff organise it."
- Information was shared with hospitals when people visited. Each person had an information sheet that would accompany the person to hospital. This contained essential information about the person, such as how they communicated, mobility and medicines.

Adapting service, design, decoration to meet people's needs:

- Oakhill House Care Home was purpose built to provide care and support for people. It had been built and designed to provide a spacious and comfortable environment. The first floor of the service is currently closed.
- People could choose to sit in the spacious lounges, dining areas or in their own rooms.
- People's rooms remained personalised and individually decorated to their preferences. We saw that people's rooms reflected their personal interests.
- The garden areas were well designed and safe and suitable for people who used walking aids or wheelchairs.

Ensuring consent to care and treatment in line with law and guidance:

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

- We were told that not everyone currently living at the home had the capacity to make their own decisions about their lives and were subject to a DoLS.
- There was a file kept by the registered manager of all the DoLS submitted and their status. The documentation supported that each Dols application was decision specific for that person. For example, regarding restricted practices such as locked doors, sensor mats and bed rails.
- Staff received training in the MCA and DoLS. They understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. The staff we spoke with confirmed this. One member of staff told us, "Some people can no longer make some decisions and we need to support them in the safest way, we have best interest meetings with the family, G.P and involve advocates if necessary."

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

At the last inspection on 11 and 14 May 2018, we asked the provider to take action to make improvements to ensuring people's dignity and wishes in relation to privacy were respected and this action has been completed.

Ensuring people are well treated and supported; equality and diversity:

- Staff had good relationships with people, and knew them well, including their likes and dislikes. Staff spoke of people's needs and social history, which was reflected in people's care plans. Staff were caring towards people, and respected people's wishes. One person said, "They (the staff) are really very kind, so patient." A second person commented, "I couldn't ask for nicer people, they always smile and talk to us kindly."
- People were treated with kindness and were positive about the staff's caring attitude.
- We saw friendships had developed between people, and staff supported people to sit with people they knew.
- Equality and diversity continued to be promoted and responded to well. Staff supported people to wear clothes of their choosing, helped people with their hair and make-up. People looked well dressed and smart. A visitor said, "I appreciate the way that the staff help my wife with her hair, she always took great care in herself and staff do her proud now she can't manage it." The laundry was well organised and people appreciated this. One person said, "My clothes come back clean and pressed." Staff ensured people were appropriately dressed in their own clothes.

Supporting people to express their views and be involved in making decisions about their care:

- People and families continued to be involved in reviews. People told us they had been involved in planning their care. One person told us, "I speak to staff about my health and they explain things to me, they arrange for me to the doctor and dentist." A visitor said, "They involve us in all care decisions as my relative can't make decisions anymore, I can't fault them."
- Records confirmed regular meetings were held with people and their relatives to discuss care.
- Multi-disciplinary meetings being held and we saw people were involved in these meetings to discuss their needs and make decisions about the care.
- Where required people and their relatives were referred to external professionals for advice and support. These were then entered in the care plan for reference. For example, dieticians and dementia experts.
- People were supported to make day-to-day decisions for themselves and were provided with information in formats which best suited their preferred mode of communication.

Respecting and promoting people's privacy, dignity and independence:

- People's right to privacy and confidentiality remained respected. One person told us, "Staff respect my privacy and at the same time they knock on my door and ask if I am okay." A visiting professional

commented, "I've never had any concerns about the staff, they respect people's privacy when I visit."

- Throughout the inspection staff treated people respectfully. When a person became agitated in their bedroom, staff responded quickly and were calm, polite and comforted the person until they became calm. There were many examples of respectful interaction seen throughout the inspection visit.
- People were supported to maintain and develop relationships with those close to them, social networks and the community. Relatives were regularly updated with people's wellbeing and progress.
- People's communication needs had been assessed and information was presented in a format that was appropriate for them.
- Staff continued to treat people with dignity and respect and provided support in an individualised way.

Is the service responsive?

Our findings

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

People's needs were not always met. Regulations may or may not have been met.

At the last inspection on 11 and 14 May 2018 we asked the provider to take action to make improvements to the pre-admission assessments and end of life documentation and this action has been completed.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- Care delivery people received was individual to their needs, however, people's individual social needs were not always planned for and there was very little stimulation for them. During the inspection, 17 people sat in the main communal lounge. Eight of those 17 people remained asleep until just before lunch. The activity person spent the morning painting the ladies' nails but there was nothing for the gentlemen. No other engagement was undertaken. In the afternoon there was a bingo session but not many people took part and the bingo was not to everybody's taste or ability.
- The activity room was not used to its full potential, and was not used for activities. Staff told us it was mainly used for the lunch service. The activity person had only just moved in to the post and confirmed that she had had no experience or training in relation to health and social care skills and none in relation to social activities, care planning or assessment skills. Her approach with people however was lovely and on a one to one basis people enjoyed the attention.
- External entertainers visited usually weekly such as singers and once a month there was armchair exercise class. Staff told us, "We know activities need to improve, we do talk about it," and "When we can, we sit with people and chat, we have singers visit which people love."
- The area manager confirmed that staff discussions had taken place and there were plans to develop the activity provision and to provide support and training to the activity person. He also confirmed due to staff changes and recruitment of new staff, training and people's physical care had taken priority. We acknowledged the fact that the registered manager and staff were aware of the need to improve people's social outcomes. However, this was an area that required improvement to improve people's social outcomes.
- Care plans contained information about people's diverse physical, social and mental health needs. Their history, likes, dislikes, sensory needs and any preferences for the delivery of their care was recorded. However, as discussed with the registered manager, these needed to be developed to include clear individual directives for staff to follow to ensure all staff provided consistent safe care.
- Oral hygiene was an area that needed to be developed and monitored. There were several people that did not have suitable tooth brushes or dental equipment in their bedrooms. Peoples' care plans did not have oral health assessments or guidance for tooth care in them.

We recommend that that expert advice be sought regarding oral hygiene in line with the National Institute for Health and Care Excellence (NICE) guidance 'Delivering better oral health'.

- People's religious needs were considered and we saw that different faith service were held within the

home.

- Reviews took place to ensure people's needs were met to their satisfaction and involved of their family or legal representative. Where people had specific health care needs, these were clearly identified and staff could explain where and how this support should be provided.
- Where an advocate was needed, staff supported people to access this service.
- People's needs were attended to quickly. There was always a staff presence in the communal areas. Not many people could use a call bell but people who remained in their rooms were regularly checked by staff.

Improving care quality in response to complaints or concerns:

- There was a process for recording and investigating complaints.
- There was a complaints policy available in written and pictorial format. People and their families also had access to a 'service user guide' which detailed how they could make a complaint.
- Some people told us they knew how to make a complaint. One person said, "I know how to make a complaint; I would go to the manager." A second person told us, "I've got no complaints about anything and feel happy living here."
- We saw complaints and concerns were minimal. The service had one complaint logged and the registered manager had acted on this.

End of life care and support:

- The management team and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment.
- This included having 'anticipatory medicines' available, so people remained comfortable and pain free.
- End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected when they reach that stage. Where people had chosen not to engage or could not participate in these conversations, with the person's permission, discussions had been held with family and those closest to them.
- There was no one at this time that was receiving end of life care.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Aspects of leadership and management did not consistently assure person-centred, high quality care.

At the last inspection on the 11 and 14 May 2018, we asked the provider to take action to make improvements to the quality systems and processes that assess, monitor and mitigate risks to people. and whilst improvements had been made there were still improvements needed and to be and embedded in to everyday practice to ensure safe and consistent care.

Understanding quality performance, risks and regulatory requirements:

- Quality assurance processes had been developed. These included audits of care plans, staff files, complaints, safeguarding concerns, incidents and accidents, and quality satisfaction surveys.
- The provider's systems had not identified some of the shortfalls we found. For example, a comprehensive Legionella and Water Safety Risk Assessment was undertaken on the 13 December 2018. This assessment document indicated a number of shortfalls that had led to recommendations in category 1 (3 months) and category 2 (6 months). There was no improvement plan relating to the work. Infrequently used water outlets were scheduled to be flushed on a weekly basis, particularly the 2nd floor as it is vacant. Records told us weekly checks were not done regularly.
- There were a number of unfinished maintenance issues. For example, one person's ensuite had been upgraded but the tiling had not been finished or sealed behind the toilet which meant it was a possible source of cross infection due to it being porous. There was a need develop the environmental audit to ensure when issues were noted that timeframe was recorded with the action needed.
- The induction process for new staff had not been completed as per the organisational policy. This meant that staff had been working unsupervised without being signed off as competent.
- Staff and the management team had identified the social needs of people were not being consistently met. They could say what needed to be done but these had not been taken forward with a plan of action such as training to address the shortfall.
- We spoke with the registered manager and area manager who advised there were still areas of improvement to be implemented but they were proud of what had been achieved since the last inspection, which included recruiting staff, reducing the use of agency staff and the continued repair and refurbishment of the premises to ensure people's safety and comfort.
- A relative commented there had been improvements since the new provider took over and they were happy with how things were at the home. The relative identified areas that in their view had improved recently, such as staff engagement.

Working in partnership with others:

- Since the last inspection the organisation had worked hard to improve partnership working with key organisations to support the care provided and worked to ensure an individual approach to care.
- There was partnership working with other local health and social care professionals, community and

voluntary organisations. Visiting health and social care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Communication has certainly improved and we feel that the management team are now working with us to improve care for people," and "Staff listen and are knowledgeable about the people they support."

- There were connections with social workers, commissioners and the community team for people who lived with dementia.

Managers and staff being clear about their roles:

- There was a management structure in place, which gave clear lines of responsibility and authority for decision making about the management of the service and provided clear direction for the staff. The management structure consisted of the registered manager and deputy manager within the service who reported to the area manager and then the provider.

- Staff had clearly defined roles and were aware of the importance of their role within the team.

Engaging and involving people using the service, the public and staff:

- There was a positive workplace culture at the service. Staff said they had been able to raise concerns and felt listened to.

- Staff worked well together, and there was a shared spirit of providing a good quality service to people. One staff member said, "Good place to work, very supportive manager and team."

- Staff had team meetings and discussed various topics such as any changes in people's needs or care, best practice and other important information related to the service. The registered manager sought feedback from the staff through regular meetings and day to day communications. The team discussed various topics in the meetings including the support and care of people who use the service, policies and procedure, tasks and actions to complete, any issues and ideas.

- Regular feedback was sought from people who used the service and their relatives or advocates. This was used to inform the provider how well the service operated. These surveys were collated and the survey outcomes shared with people, families and staff. The actions to be taken were also shared. One visitor said, "I visit everyday so continuously give feedback, they are so kind and understand how I feel as well as caring for my wife."

Continuous learning and improving care:

- The registered manager told us they used accidents, incidents, complaints and safeguarding as learning tools to improve the service. This was confirmed by the documents seen and from the staff we spoke with. One staff said, "We monitor all falls and injuries, we then contact the falls team for advice and this has really helped and reduced falls." The lessons learnt were used to enhance staff knowledge and to improve on the service delivery.

- Accidents and incidents were documented and recorded. Incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated learning from incidents and accidents took place.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:

- People, family and staff felt they could talk to the registered manager and staff at any time and the regular meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One visitor said, "I can talk to the staff, they listen and take action."

- The provider was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support when untoward events occurred. The service had notified us of all significant events which had occurred in line with their legal obligations.
- All staff were keen to emphasise the service would advocate for people if required. For example, in respect of ensuring medicine reviews took place. This meant people were only on the medicines currently required as opposed to taking those which were no longer relevant or the best for the person.