Eastwick Barn Limited

Patcham Nursing Home

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Patcham Nursing Home on 31 July 2018. Patcham 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. Patcham Nursing Home is registered to accommodate up to 30 people, some of whom were living with dementia and other health conditions. Patcham Nursing Home is comprised over two floors, with two lounges and a dining area. There were 27 people living at the service during our inspection. We previously inspected Patcham Nursing Home on 27 June 2017 and found areas of practice that needed improvement. Some improvements had been made, however, we found further areas of practice that needed improvement.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The culture and values of the provider were not embedded into every day care practice. Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of cohesion and a negative culture in the service. Some staff did not have a good understanding of equality, diversity and human rights. We have identified this as an area of practice that requires improvement.

On the day of our inspection, staffing levels were appropriate. However, we received mixed feedback from people and staff in relation to staffing levels. Documentation showed that on several occasions, shifts had gone ahead with less staff than had been assessed needed. We have identified this as an area of practice that needs improvement.

We have made a recommendation in respect to equality, diversity and human rights.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people at the end of their life. Staff had received both supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Risks associated with the environment and equipment had been identified and managed. Emergency

procedures were in place in the event of fire and people knew what to do, as did the staff. The service was clean and procedures in relation to infection control were robust.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people, massage and manicures, and themed events, such as reminiscence sessions and visits from external entertainers People were also encouraged to stay in touch with their families and receive visitors.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. People's end of life care was discussed and planned and their wishes had been respected.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The assessed number of staff required on each shift had not always been maintained. Feedback was mixed in relation to staffing levels.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely. Infection control protocols were routinely followed.

Staff understood their responsibilities in relation to protecting people from harm and abuse. The provider used safe recruitment practices. Systems were in place to ensure accidents and incidents were reported and acted upon.

Is the service effective?

Good

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity was respected and their

independence promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them. People's end of life care was discussed and planned and their wishes had been respected.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some staff feedback indicated dissatisfaction with working at the service, and a negative culture. Some staff did not have a good understanding of equality, diversity and human rights.

People were able to comment on and be involved with the service provided to influence service delivery.

Quality assurance was measured and monitored to help improve standards of service delivery.

Patcham 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 was planned to check 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 31 July 2018 and was unannounced. The inspection team consisted of two inspectors 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.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. We spoke with six people, three relatives, three care staff, the activities co-ordinator, a registered nurse, the chef, the deputy manager, the regional manager and the registered manager. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including five people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 27 June 2017, we identified an area of practice that needed improvement. This was because we found issues in relation to safe administration of medicines procedures being followed. At this inspection we saw that improvements had been made. People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "I feel safe, because I have never been abused by anyone or shouted at". Another person said, "I feel safe having people around me". A relative added, "I think [my relative] is safe here, because there is always someone around for him". However, despite the positive feedback, we saw areas of practice that need improvement.

On the day of our inspection, staffing levels were appropriate to meet the needs of people living at the service. However, we received mixed feedback from people and staff in relation to staffing levels. One person told us, "I feel safe here, because of all the staff around and they come when I press the bell". Another person said, "If I ring the bell they come as quickly as they can. They don't leave you waiting longer than they have to. They could do with more staff particularly at night". A further person told us, "Staff are busy all the time. The response to the bell varies and on the whole, it is not too bad". A relative added, "They are pushed at times especially meal times". Staff told us that the service had frequently operated on some shifts without the assessed number of care staff and this had impacted on their ability to deliver care in a way that was person centred and protected the wellbeing of staff. One member of staff told us, "The residents are safe, but we often don't have enough staff on shift. It affects my wellbeing and means that everything is stressful and rushed, which is not good for the residents". Another member of staff said, "When we are short staffed, we can get things done as a bare minimum, but that isn't good for anybody. It means we can't spend enough time with people". The registered manager told us that staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. They said that existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. However, we looked at staffing rotas for the previous two weeks and saw that on seven occasions the service did not have the assessed number of care staff working on shift. People had not come to any harm during this time. However, the feedback received from people and staff demonstrated that on days when the service did not have the assessed number of care staff working, that this had a negative impact on care delivery and the wellbeing of staff. We have identified this as an area of practice that needs improvement.

We looked at the management of medicines. Since the last inspection, the registered manager had introduced new systems into the service, and people's medicines were now stored within their rooms. Registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a registered nurse giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "I often have pain and the staff react quickly and give me medication". A

relative added, "They know [my relative's] history and are always prompt with her medication". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the Nursing and Midwifery Council (NMC).

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. One person told us, "It is always clean here". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves was readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. Infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns. There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people.

Good

Is the service effective?

Our findings

At the last inspection on 27 June 2017, we identified an area of practice that required improvement. This was because we found issues in relation to staff receiving essential 'refresher' training in a timely manner. At this inspection we saw that improvements had been made.

The registered manager told us that mandatory training was now up to date for all staff and we saw that this was the case. Staff had received training in looking after people, including safeguarding, food hygiene, health and safety, equality and diversity. They also received training specific to peoples' needs, for example around the care of people at the end of their life. Staff told us that training was encouraged and was of good quality. Staff including registered nurses told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. One member of staff told us, "There is a constant push on training". Another said, "It's all about the training". People also agreed that staff were well trained. One person told us, "I need all physical care and they know what they are doing to help me". A relative said, "They know what they are doing. When [my relative] was first here we didn't think he would get to where he is today". A further relative added, "[My relative] is getting the best care possible". Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We received mixed reviews from people in relation to the quality of the food. However, on the day of our inspection when we observed lunch, the food looked tasty and was well received. People told us they could have an alternative meal, should they not want the one on offer. One person told us, "I get curry on a Friday, because I don't like fish and chips". People were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission and specialist diets were catered for.

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 when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured when people were referred for treatment they were aware of what the treatment was and the possible outcomes. We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them. One person told us, "I can call a nurse if I feel unwell and they will get a doctor".

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service and there were slopes for wheelchairs. Other parts of the service were accessible via a lift and there were adapted bathrooms, showers and toilets.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "I love it here. Everyone is so good, friendly and helpful. They keep me going. They run around after you and look after you". Another person said, "I love it here, everyone is so good, I think God saved these rooms for us". A further person added, "They have treated me well from the time of my arrival".

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. One person told us, "I came here to die four years ago, but when you have a place like this to live in, you don't want to go". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. Staff also knew about peoples' families and some of their interests.

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "The staff generally know me well, my needs and wants". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "I offer choices around what people want to wear, what food they eat and what they would like to drink".

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "It is nice here and the fact that it is nice is what keeps me going. Lovely home, lovely people". A member of staff added, "I treat residents as an extension of my family. Once you get to know them, we get really comfortable with each other".

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "Definitely treated with respect and dignity". A relative said, "Privacy and dignity are always respected".

Staff supported people and encouraged them, where they were able, to be as independent as possible. For example, people could access the local community, which helped them to continue to make daily living

choices. One person told us, "The staff are always on hand. The place is locked up but I can go out if I want if I let the staff know I am going out. There is a number to press on the door pad to get out and a button outside to press for someone to let you in". Care staff also informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "I get people to try and do things for themselves. Basically, whatever they can do, I give them a nudge in the right direction".

Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way friendships were formed within the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together.

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one.

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. Staff told us how they adapted their approach to sharing information with some people with communication difficulties. One member of staff told us, "We use picture cards with some people to help us communicate". Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "This is a home and I like it. I am happy. They are always asking me how I am and what I need". A relative added, "[The registered manager] is lovely. If anything wasn't right I would go straight to the manager".

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. For example, we saw that picture cards and a writing board were used to assist some people. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required. Technology was used to support people to receive timely care and support. The service had a call bell system which enabled people to alert staff that they were needed.

Keeping occupied and stimulated can improve the quality of life for a person, including those living with dementia and those who remained in their rooms. We saw a varied range of activities on offer, which included, manicures and themed events, such as reminiscence sessions and visits from external entertainers. People told us that they enjoyed the activities. One person told us, "The activities co-ordinator is brilliant at keeping me occupied". Staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms and provide specific personal activities. One person told us, "The activities co-ordinator takes me to town to do a bit of shopping". Staff also supported people to maintain their hobbies and interests. One person told us, "I help the gardener the best I can".

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. Although nobody we spoke with could specifically remember being involved in the planning of their care, documentation confirmed that information had been drawn together by the person, their family and staff. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "The care plans are useful, as some people have a very specific way that you need to give their care". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily

routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. We saw that the registered manager liaised with a local hospice in order to deliver training for staff to enable them to deliver dignified end of life care to people.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke highly of the care delivered, felt involved in the running of the service and that it was well-led. One person told us, "The staff are wonderful, they work so hard, but are happy and never moan. They are never rude or brisk". Another person said, "I had a choice of paint colour for my walls". A relative added, "There are monthly resident and family meetings where you can raise issues and they are acted on". A further relative told us, "We looked at five or six homes and chose this one because of the feeling we got when we first walked in". However, despite the positive feedback, we identified areas of practice that require improvement.

We discussed the culture and ethos of the service with the registered manager and staff. Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of cohesion and a negative culture in the home. One member of staff told us, "I am happy here and feel supported". However, another member of staff said, "Morale is very low here, we support each other as carers, but that's because we have to. It feels like nobody has our back, management should have done more by now to sort out the issues between staff". A further member of staff added, "I've not seen any discrimination specifically, but I know there are issues between some staff. I sometimes feel that I raise things, but nothing gets acted on". Other comments from staff included, "Senior management haven't done enough to support us, there have been problems between management, staff and some families" and "There has been some bullying going on between staff. I don't think management has supported enough". The regional manager told us a lot of work had been done around culture and morale and that meetings had been put in place for staff to discuss any concerns. However, we found that the culture and values of the provider were not embedded into every day care practice. Feedback from staff was not always positive about the culture of the home.

Furthermore, we received feedback that some staff felt discriminated against. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Some staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. However, when we discussed the feedback in respect to discrimination with some members of staff, we heard incorrect terms and language used when discussing equality, diversity and ethnicity.

The culture of a home can directly affect the quality of life of residents. A positive culture has the ethos of care built around the resident, and acknowledges the importance of fostering positive relationships between residents, relatives and staff as the foundation to quality of life. Staff working as an effective team, with mutual appreciation and some blurring of roles, improves team performance and will impact positively on the quality of life for people and the wellbeing of staff.

The provider had not ensured that feedback from staff had been acted upon. Furthermore, the day to day culture in the service, including the attitudes, values and behaviour of staff did not promote a positive ethos that was open, inclusive and empowering. We have identified this as a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is an area of practice that requires improvement.

We recommend the provider obtains and delivers training to staff from a reputable source in relation to equality, diversity and human rights.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety, infection control and medication. The results of which were analysed in order to determine trends and introduce preventative measures. Up to date sector specific information was also made available and we saw staff had also liaised regularly with the Local Authority and the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery.

We saw that people were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. There was information displayed around the service to encourage people to feedback their opinions of the care they received, and meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

Up to date sector specific information was made available for staff, including guidance around the Mental Capacity Act 2005 and responsibilities in relation to recognising and acting on abuse. We saw that the service also liaised regularly with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(2)(e) HSCA RA Regulations 2014 Good governance The provider had not ensured they had sought and acted on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving the service. The day to day culture in the service, including the attitudes, values and behaviour of staff did not promote a positive ethos that was open, inclusive and empowering.