

Bethesda Healthcare Ltd

Otterbourne Grange Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

About the service

Otterbourne Grange Residential Care Home is a residential care home providing personal and nursing care to 22 people at the time of the inspection. The service can support up to 25 people under and over the age of 65, some of whom may be living with dementia.

People's experience of using this service and what we found

We found several concerns regarding the standard of cleaning and were therefore not assured that people were protected from risks associated with poor cleanliness. Since our visit, a deep clean of the service has been carried out. We were assured about other areas of infection control.

In line with recommendations in a fire risk assessment completed in March 2021, the provider had installed a break glass case with padlock key next to the dining room and lounge doors. This was to ensure that they could be used as an escape route in an emergency; however, we were not assured that all staff were fully aware of those evacuation procedures. The provider has since taken additional precautions and made all staff aware.

Health and safety checks were completed consistently to ensure the safety of the environment.

We received feedback that staffing levels had been low; however, the provider was addressing this concern and improvements had been made. Staff were recruited safely, and we observed staff supporting people in a kind and attentive way. Staff received a range of training and had access to group and individual supervisions.

We identified that in one case, staff were not working in line with best practice guidance when administering a person's medicines, which could have put the person at risk. The provider took immediate action to review the practice and ensure that the person received their medicines safely. Overall, medicines management systems were robust, and we were assured that people received the right medicines at the right time from staff who had received appropriate training.

People mostly had detailed and person-centred care plans in place, which also addressed any risks identified. The provider had identified that not all care plans were fully up to date, and a quality assurance manager had been appointed whose initial focus was to review these.

We observed people enjoying a comfortable mealtime with food and drinks of their choice. Staff supported people in line with their requirements and in a dignified way.

People's relatives told us that communication with them needed to be improved and they were not always involved in planning their relatives' care.

The nominated individual and operations director had started working with the home in March 2021 and had implemented robust quality assurance systems. The leadership team was committed to driving improvements to the service and had detailed action plans in place to facilitate this.

Staff told us that they had previously not felt listened to and that their concerns had not been acted upon. However, we received positive feedback about the current leadership team. Staff told us that they could see successful changes being implemented in the home and felt their concerns were now being addressed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

At the last comprehensive inspection (published 24 August 2019), the rating for this service was requires improvement and multiple breaches of regulation were identified. The provider completed an action plan after the last inspection to show what they would do and by when to improve. A targeted inspection was later carried out and the last rating for this service was requires improvement (published 17 December 2019). At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 04 June 2019. Breaches of legal requirements were found in relation to safeguarding service users from abuse and improper treatment, good governance, employing fit and proper persons and safe care and treatment.

A targeted inspection took place on 05 November 2019 to check whether the Warning Notice we previously served in relation to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met on a specific concern we had about the provider not ensuring that risks to people were appropriate assessed, or plans developed to mitigate the risks and professional guidance being followed. At that inspection, enough improvement had been made and the provider was no longer in breach of regulation 12. Other key questions and breaches of regulation were not assessed at that inspection.

We undertook this focused inspection to check the provider had followed their action plan to improve safeguarding service users from abuse and improper treatment, good governance and employing fit and proper persons, and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Otterbourne Grange Residential Care Home on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information 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 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 well-led?

The service was well-led.

Details are in our well-led findings below.

Good 

Otterbourne Grange Residential 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

Otterbourne Grange Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The provider was recruiting a manager and had appointed an acting manager to oversee the service with support from the operations director.

Notice of inspection

We gave a short period notice of the inspection because we were mindful that there was no registered manager in place, and we wanted to ensure the provider could support the service during the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with six people using the service. As some people were not able to share their experience of using the service with us, we also spent time observing interactions between people and staff. We spoke with six members of staff, including care workers, a senior care worker, a chef, the operations director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with a health professional who regularly visits the service. We reviewed a range of records. This included five people's care records and multiple medicines records. We looked at staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at further training data, quality assurance records and care records. We sought feedback from six relatives and five members of staff.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant 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.

Preventing and controlling infection

- We were not assured that people were protected from the risks associated with poor cleanliness.
- Cleaning records had been completed which showed all areas had been cleaned, including shower rooms and shower chairs. However, we carried out observations and found several concerns. Two shower chairs in one shower room were soiled with faeces and the soap holder was cracked. There was built up grime around the legs of commodes, toilet bases and skirting boards in two of the shower rooms. There were strong malodours in one area of the home. One person's easy chair in their room was badly soiled. One relative told us, "Sometimes it doesn't smell nice, you know."
- Paintwork on and around some windowsills and doors in the home was damaged, peeling and dirty. Walls in the dining room and lounge were stained and had splashes of food down them and a sink in the dining room was cracked.
- The nominated individual told us they had arranged for a deep clean to be carried out on the day of our inspection, which they had postponed due to our arrival. However, most of the issues we found should have been dealt with through daily, thorough cleaning and regular maintenance. Following the inspection, the provider sent us confirmation that a cleaning company had completed a deep clean on 19 June 2021. The provider also told us they were reviewing and planning to increase housekeeping hours so that additional cleaning could be carried out in the afternoons.
- The laundry room was tidy and well organised and there were separate colour coded laundry baskets for different types of laundry, including a red basket for soiled laundry.
- Clinical waste and used PPE were disposed of appropriately in yellow bins provided.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

At our last comprehensive inspection the provider had failed to ensure that recruitment procedures were safe and effective. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- Records showed that appropriate checks were carried out to ensure that prospective staff were safe to work with vulnerable people. The provider had plans to involve people in the interviewing process by establishing what qualities and personality traits were important to them and ensuring that this was considered when appointing new staff.
- Relatives gave us mixed feedback about staffing levels. Some relatives did not have any concerns or felt unable to comment on staffing levels, as they had had limited contact with the home. One relative told us, "I think they're very busy, there's just not enough staff." Another relative said, "I've done a few visits but it's very quiet and no one seems to be around. What are they actually doing with the patients? Are they just left to do nothing?"
- Staff told us that there had been significant staffing challenges, but that these were now being addressed. One member of staff said, "Our new [interim] manager, [they're] actually one of the first people, [they've] noticed the same things and increased staffing."
- The provider told us about the challenges they had been experiencing with regards to recruitment of staff, but that this was an area they had been focusing on heavily and recruitment was now more successful.
- The provider used a dependency tool that the manager reviewed on a weekly basis. This, alongside observations and feedback from staff, was used to determine safe and appropriate staffing levels. The provider had recently increased staffing levels in line with people's needs and increased occupancy of the home.
- We observed staff supporting people in a kind and attentive way. Staff took their time to support people and did not appear rushed. One person told us, "We're very lucky. The staff are lovely, so kind." Another person said, "The staff are helpful. I like it here".

Using medicines safely

- We identified that for one person, staff were administering a tea-time dose of medicine and leaving a night-time dose of medicine at the same time with the intention of the person taking their night-time medicine independently, as they did not like to be disturbed later in the day. Whilst this showed a staff desire to work in a person-centred way, this was not reflected in the person's care plan or medicines administration record (MAR) and there were risks associated with this practice. The provider took immediate action to review the situation and ensure that staff followed best practice guidance.
- People had individual medicines administration records (MAR), which included a photograph of the person, their date of birth and information about any allergies. Overall, we were assured that people received the right medicines at the right time. One relative told us, "They've been good with her tablets."
- Systems in place for ordering, securely storing and returning any unused medicines were robust. This meant that people received effective medicines as prescribed.
- For 'as required' (PRN) medicines, protocols were in place to help staff identify whether a person needed their PRN medicines and when medical advice was required. This meant that people who were unable to communicate their needs, were able to receive their PRN medicines when they were required and that their effectiveness could be monitored.
- Covert administration was used in line with legal and good practice frameworks. Staff told us covert

administration was used as a last resort and we saw that health professionals had been appropriately consulted.

- Staff had received appropriate training to administer medicines.
- The provider had robust quality assurance systems in place to monitor medicines management. Where these had identified concerns, action plans were implemented to rectify these. For example, following a recent issue identified, the provider had implemented additional checks and practical competency assessments for staff.

Assessing risk, safety monitoring and management

- The home had systems in place to ensure that fire safety equipment, such as extinguishers, fire doors, emergency lighting and alarms, were in good working order through regular checks and servicing contracts.
- However, a fire risk assessment completed in March 2021 had identified an issue relating to the doors in the dining room and lounge being chained closed, which could prevent them from being used as an emergency escape route. The provider had installed a break glass case containing a padlock key by the doors, which could be used to remove the padlock and chains in an emergency. Documentation also stated all staff kept a key on their person to use in an emergency.
- We asked a staff member how they opened the dining room door in an emergency. They said they weren't sure and had a look behind the curtains. They saw the break glass case and said, "it might be this one. Yes, I think it's this one." We were therefore not assured that all staff understood and followed the emergency evacuation procedures. We spoke with the nominated individual about our concerns, who reviewed precautions and took action to ensure all staff were confident about evacuation procedures.
- Appropriate checks and servicing were carried out as required on other equipment, for example, electrical installations and appliances, call bells, sensor mats, hoists and air flow mattresses.
- A legionella risk assessment had been completed and actions identified had been addressed. We saw there were appropriate on-going checks of the water system to reduce the risks of legionella bacteria developing.
- People had a range of risk assessments in place, for example, in relation to the risk of falls or the risk of skin breakdown. These provided staff with guidance for how to manage and reduce these risks.
- Staff used nationally recognised tools to monitor risks to people, which were overseen by the leadership team. This included measures such as weights and the monitoring of food and fluid charts. The provider told us they were working on senior carers and carers becoming more involved in the monitoring process.

Systems and processes to safeguard people from the risk of abuse

At our last comprehensive inspection the provider had failed to ensure systems were in place to keep people safe. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- Staff had received training and were aware of their safeguarding responsibilities. Staff told us they were confident that if they raised concerns to the leadership team, their seniors or managers would listen and take appropriate actions to protect people. One member of staff said, "Yes, I could definitely raise it, especially if there was abuse or neglect of anything, definitely, I would have no hesitations."
- We saw that incidents of a safeguarding nature had been raised appropriately to the local authority, as well as being investigated by the provider.

Learning lessons when things go wrong

- People's relatives told us that when incidents took place or their relative was unwell, they were promptly informed. On relative said, "They always tell me if there's been an upset or if [they've] had a fall, they'll always tell me so I've no complaints in that respect."
- Incidents and accidents were recorded, investigated and any learning from these was reviewed and shared to try to prevent future occurrences. The manager and provider monitored the incidents that occurred each month to identify any wider themes or trends.
- The provider arranged meetings and debriefs with staff following incidents, to reflect and identify learning, which could then be shared with the wider staff team.
- The provider had notified the local authority safeguarding team of any incidents or accidents as required.
- The nominated individual and operations director spoke transparently about the challenges they had experienced or identified since they had started overseeing the home in March 2021. Action plans were in place to continue to drive improvements to the home.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people's outcomes were overall good, and people's feedback confirmed this.

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

- People were involved in planning and reviewing their care, however, most people's relatives told us that they had not been involved in creating or reviewing their family members' care plans. The provider had already identified this and was planning to make improvements.
- Staff told us that care plans were not always fully up to date and did not always contain enough guidance and information to help them meet people's needs. One member of staff told us, "Some of them are quite, I would say, all over the place. But they've started fixing them up." Another member of staff said, "At the moment I don't think there is enough information in care plans." However, staff knew people well and told us the provider had identified the issues and they could see improvements to care plans were already being made.
- One person's care plan had not been updated when their needs changed, and another care plan contained a generic statement that did not apply to the person. However, most care plans reviewed were detailed and person-centred.
- Shortly after the inspection visit, the provider appointed a new quality assurance manager, whose initial focus is to review people's care plans and ensure they are up to date and contain all relevant information and best practice guidance.
- People received care that met their needs from staff who were aware of their preferences. Pre-admission assessments were carried out before people moved to the service, and their needs continued to be reviewed as they settled into the home.
- In line with best practice guidance, support plans were in place for people's oral care.

Staff support: induction, training, skills and experience

- The provider had developed a detailed and robust induction programme, however, in the case of three staff files reviewed the programme had not been fully completed. Despite this, staff told us that they had felt well supported throughout their induction and had received additional support and training until they felt confident in their new role.
- People were supported by staff who completed a range of training. Staff overall were positive about the training available to them. Some staff told us they would benefit from additional training to support people with behaviours that challenge, as they did not feel fully confident and considered the approach to be inconsistent across the staff team. The provider had already arranged additional training to take place on 08 July 2021.
- Staff new to care were supported to complete the Care Certificate, which is a national set of standards

designed for staff develop the skills and knowledge required to provide safe and compassionate care.

- Relatives told us they felt confident that staff had the skills required to support their family members. One relative said, "They really seem to know what they're doing."
- Staff told us they received effective supervision and that they could ask for additional meetings if required. The provider had recently undertaken several group supervisions to facilitate discussions amongst staff, seek feedback and embed learning or changes being implemented.
- The provider had plans to introduce a champion system, whereby individual staff would receive additional training and take on a lead role in an area.

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

- We noted that there were areas of the home that were worn and would benefit from redecorating. The provider had plans to make improvements to the building and had started decorating the outside of the building and updating outside spaces.
- We observed that there was a homely atmosphere within the service and people told us they felt comfortable. One person said, "Look at the view! It's first class" and another told us, "They [staff] take us out as much as they can".
- There were spacious communal areas available for people to spend time in, as well as their individual bedrooms. People could move freely within the environment.
- People had 'memory boxes' available outside their bedrooms doors, which were box frames they could use to display items that were meaningful to them.

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

- We observed the lunch meal being served. Staff took time to ensure people were comfortable, asking them where they wanted to sit and if they wanted to be moved in nearer to the table. Meals were served on plates with a cloche which helped to keep the food warm.
- People seemed to enjoy their food. People were offered a choice of two main meals and alternatives were available to people who did not want either main choice. For example, one person said, "I don't want mine. What else is there?" The staff member replied, "Anything you want. What would you like?" We saw one person asked for, and received, an omelette and another had a sandwich, which they ate.
- The chef came into the dining room to check that everyone was happy. They were smiling and chatty and used terms of endearment with people. They asked, "Is everyone alright? Are you enjoying it?" Responses were all positive, for example, "Yes, it's a lovely bit of meat" and "I enjoyed that" and "That was lovely, thank you." One person told us, "The food is lovely. There's plenty of food and we do get alternatives and choice." Another person said, "I had a beautiful breakfast. The food is alright. Sometimes I could do with a bit more." The person had not thought to ask for second helpings but after our discussion we saw that they asked for another helping of their lunch.
- Where people had difficulty cutting up their food, staff offered to do this for them and respected their choices.
- People were offered choices of drinks throughout their meal and these were topped up frequently if people wanted more.
- We spoke with the chef who explained how they tried to involve people in the menu choices. They monitored the success of dishes which were reviewed, such as steak and kidney pie which was popular, and others which were not, such as chicken curry.
- The chef told us people "eat with their eyes." All meals were freshly prepared and they tried to make meals look appetising and plate up appropriate portions for people's needs and preferences.
- Staff requested appropriate support for people when they developed eating difficulties. One person had been referred to the speech and language team for an assessment of their eating needs. They were still waiting for this to take place.

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

- People's relatives told us that staff identified when their family member was unwell and made referrals to health professionals when required. For example, one relative said, "They rang me to say [person] needed to go to the dentist, [they] had a toothache."
- Records showed staff identified when professional advice needed to be sought and referrals were completed in a timely way.
- We spoke with a health care professional during their weekly visit to the home to check on people's health. They had no concerns about how people were cared for by staff. They said staff knew people well and would call the surgery promptly if they were concerned about a person's health.
- They told us they thought [the new acting manager] seemed 'very switched on'. They also told us the home had pharmacy and district nursing support from the surgery. District nurses had also provided training, for example with dressings.
- Where advice had been provided by a professional, such as from a speech and language therapist or from a mental health professional, this was included in the person's care plans.

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 when this is in their best interests and legally authorised under the MCA. 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- When required, the leadership team had ensured that these authorisations had been applied for.
- Staff were passionate about providing care in line with people's wishes and gaining their consent. For example, staff told us that one person did not like to be disturbed in the evenings and that wherever possible they tried to respect this.
- Staff were aware that people had the right to refuse care and understood the principles of the MCA. Staff told us about how they used a variety of approaches to support and encourage people who did not understand the risks associated with declining care. This included returning at another time, using different members of staff or employing distraction techniques.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives told us they had felt less involved in their family members' care throughout the COVID-19 pandemic. Most relatives felt unable to provide their views, because they felt their limited contact with the home meant they did not have enough experience of the quality of care. For example, one relative told us, "I couldn't say, before Covid we were up there one and a half, two hours and we got a picture of how the home was run and how they operate, but not being able to visit you lose that perspective."
- Despite this, most relatives told us they had confidence in their family members' care and safety, but that communication needed to be improved and more proactive. For example, one relative said, "I mean we're happy [person's] safe, [they] look well..., day to day [they're] clean, fed, but there's just no communication, it's not good." Another relative told us, "Communication, it's only when I ask on the phone, no one rings me, that's been the same from the start. But surely, they shouldn't be waiting for something to go wrong, surely they should be keeping me updated."
- The provider had identified the need to improve the inclusion of relatives in the service and had created an action plan to drive this forward. The interim manager had already started contacting people's relatives to introduce themselves.
- Staff told us that until recently, they had not felt well supported within the service and that concerns they had raised had not been listened to. However, since the new leadership team had started, staff told us they felt well supported and could see that positive changes were being made. One member of staff said, "Everything I had concerns about, I did say and [leadership] listened". Another member of staff told us, "At the moment, I do feel supported, before I didn't, I didn't feel supported at all."
- People had regular opportunities to provide feedback about their care through six monthly reviews of their care plans and monthly residents' meetings. People's feedback was also sought as part of the provider's audit system.
- People's care plans were overall person-centred and contained details about their background and preferences.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Services registered with the Care Quality Commission (CQC) are required to notify us of certain events such as deaths or serious injuries. We found that we had not been notified of a safeguarding incident. However,

appropriate actions had otherwise been taken to reduce risks to people. The provider has implemented additional checks to ensure that the leadership team notifies us of incidents in line with our regulations.

- The home was usually managed by a home manager with support from a deputy manager. An interim home manager had been appointed and the provider was recruiting a permanent home manager to become registered with CQC. The management team was supported by the provider, with both the nominated individual and operations director taking an active role in quality assurance. A new quality assurance manager had also been appointed.
- The provider shared their plans to review the chain of command and supervision structure so that senior carers would take a more active role in monitoring the quality of the service.
- The provider displayed the most recent CQC rating on their website and at the service.

Continuous learning and improving care

At our last comprehensive inspection the provider had failed to establish effective systems and processes to ensure compliance with the requirement of the regulations. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- The provider had a robust quality assurance system, which monitored the quality of the service. Audits were completed regularly by the manager, as well as the provider and covered a range of areas such as health and safety, medicines and infection control. Audits completed earlier in the year had not always identified issues, such as those related to the maintenance of the building. However, more recent audits were thorough. Concerns identified led to action plans, which we could see the provider was implementing.
- The provider had continued plans for improvements to the service. This included planned improvements to the building and environment, but there were also action plans in place to continue to drive improvements in the quality of care and we saw that a number of changes had already been implemented.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Relatives told us that staff knew their family member and their preferences well. One relative said, "They know [person], they get [them], so we've always been happy."
- Staff spoke passionately about people's preferences and how they tried to accommodate these. People's preferences were documented in their care plans and risk assessments were completed to support people to make choices about their care and take positive risks. For example, one person did not like to be checked on overnight and a risk assessment had been completed and agreed with the person so that their wishes could be respected. One member of staff told us, "I like helping them [people], I love getting them up in the morning, helping them choose an outfit that they're going to look their best in that day."
- In order to monitor the culture and atmosphere of the home, the leadership team considered this as part of their audits. For example, when the provider visited the home, they spent time in communal areas chatting to people, staff and observing. This also included participating in a mealtime and undertaking unannounced night-time visits.
- The provider told us they were committed to ensuring the home operated to a high standard. This had recently meant that disciplinary processes had been followed for members of staff who did not appear to uphold the values of the service.
- Records showed that when the provider identified that mistakes had been made, they apologised to

people and their relatives. Relatives told us they were always kept informed when incidents occurred involving their family member. On relative said, "I mean if anything happens, as soon as it happens, we're updated."

Working in partnership with others

- The service worked with other agencies to best meet people's care. For example, the service regularly worked with the Older Person's Mental Health Team. People's relatives told us that staff always identified when other health professionals needed to be notified or consulted.
- The provider had plans to engage with the local community. For example, the home had previously had good links with a local nursery, school and church and the leadership team were keen to nurture these links which had been challenging to maintain throughout the COVID-19 pandemic.