Thames Williams Care

# Everley Residential 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 undertook our comprehensive inspection of Everley on 15 and 18 June 2018. The initial visit date was unannounced with the second date announced. Our last inspection of Everley was on 01 December 2015. The service was rated good after this inspection.

Everley 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.

Everley accommodates a maximum of 16 older people that may have dementia or physical disabilities. People live in a building that was converted into a care home.. There was 16 people living at the home on the first day of inspection, and 15 on the second.

The provider is required to, and has a registered manager for the home. They were present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt there was enough staff to keep them safe, and respond to their requests for assistance in a timely manner. Staff were of the view additional staff may help improve people's safety and the provider was reviewing staffing levels on a monthly basis in response.

Improvement was needed to ensure that systems for infection control were effective. People received their medicines in a safe way. People felt safe and there were systems in place to identify and respond to risks. Staff were aware of safeguarding systems, although improvement in recording equipment people may use for lifting could be improved.

People's rights were promoted. Staff sought people's consent. Risks to people's health were assessed and identified. Staff were supported and had received training although some training needed update. The provider had sourced a new training provider to update staff on key areas of skill and knowledge relevant to their job. People were supported to maintain a healthy diet, good fluid intake and had a choice of meals. People were supported to access the health care they needed.

The environment was small and homely although may not always be suitable for people with limited mobility if accommodated on the first floor. There was scope for improvement in respect of the environment regarding its decoration, and safety in respect of, for example infection control.

People were supported by staff who were caring and treated them with dignity and respect. People were valued by staff. People's independence was promoted. People were supported to express and make choices

regarding their daily living. People were supported to maintain contact with significant others.

People and their representatives were involved in their care planning. Staff understood people's needs, likes, dislikes and personal preferences. People had the opportunity to engage in activities if they wished. People could make a complaint and thought they would be listened too. The provider was working with health professionals to develop ways of responding to people's wishes and needs at times when they may be unable to share these.

Systems for quality monitoring were in place, but development of these needed to continue to address some aspects of quality within the service. The management team were well known to people, relatives and staff, who considered them approachable. The provider understood their legal responsibilities and were open and honest about the challenges faced in respect of improving the service so people were safe and received good quality care. We found the provider was learning from incidents and events following input from other agencies.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe

People felt well supported when requesting assistance from staff and felt sufficient staff were available. Staff felt people were safe but additional staff would improve people's safety.

People were not always protected from the risk of infection because Improvements were needed to ensure that systems for infection control were effective.

People received their medicines in a safe way.

People told us they felt safe at the home and there were systems in place to identify and respond to risks. There were systems in place to safeguard people and staff aware of these. There was improvement in assessing equipment people needed for lifting.

We found the provider had identified learning from incidents to improve people's safety.

### Is the service effective?

**Good**

The service was effective

People's rights were promoted, and their consent sought by staff.

People were supported by staff who were knowledgeable about how to meet their needs but some refresher training was required

People were supported to maintain a healthy diet and good fluid intake

People were supported to access the health care they needed.

The environment was small and homely although as confirmed by the provider may not always be suitable for people with limited mobility if accommodated on the first floor.

### Is the service caring?

**Good**

The service was caring

People were supported by staff who they said were caring and treated them with dignity and respect. People were valued by staff.

People's independence was promoted.

People were supported to express their views and make choices regarding their daily living.

People were supported to maintain links with significant others.

## Is the service responsive?

Good

The service was responsive

People, or their representatives were involved in their care planning.

People were supported by staff that had a good understanding of their needs, likes, dislikes and personal preferences.

People were able to engage in some activities if they wished.

People could make complaints and felt these would be listened to.

The provider was developing systems to enhance how they responded to people's needs at the end of their life.

## Is the service well-led?

Requires Improvement

The service was not always well led.

Systems for monitoring the quality of care were in place, but development of these needed to continue to address some aspects of quality within the service.

The management team were well known to most people, relatives and staff, who said they were approachable.

The provider and registered manager understood their legal responsibilities and were open and honest about the challenges they faced in further improving the service so people were safe and received good quality care.

# Everley Residential 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.

The inspection was prompted in part by some concerns that we received from commissioners following one person sustaining serious injury and other people having several falls. Commissioners told us they had visited and considered some of the issues surrounding the provider's management of people's safety. We inspected to see if the provider had taken steps to address these issues related to people's safety as well as to complete a comprehensive inspection.

The inspection took place on 15 and 18 June 2018. The first day of the inspection was unannounced, the second announced.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As well as considering the information of concerned we received prior to our inspection, we reviewed other information we held about the service. This included notifications, which tell us about incidents which happened in the service that the provider is required to tell us about. The provider had completed a provider information return (PIR) prior to our inspection; this document that told us how the provider was maintaining and improving the service as well as providing other data. We also contacted other agencies such as commissioners and safeguarding teams. We used this information to help us plan our inspection.

We spoke with six people who lived at the home. A number of people living at the home were not able to clearly express their views so we spent time observing how staff provided care for people to help us better understand their experiences of the care and support they received. We carried out Short Observational Frameworks for Inspection (SOFI) to observe the people's experience of life at Everley. We spoke with three visiting relatives, the registered manager, the provider, a senior carer, three care staff and the cook. We spoke with one health care professional during the inspection. We reviewed six people's care records; four

medicine administration records (MARs) and three staff files. We also looked at other records relating to the management of the service, for example audits and certificates of safety for equipment.

Requires Improvement

# Is the service safe?

## Our findings

We heard concerns from the local authority prior to our inspection that risks to people's safety were not managed well, which had potentially left people at risk of harm on occasion. For example, there had been a lack of clarity as to the procedure to follow when a person fell, and when paramedics should be contacted. We spoke with the registered manager and staff and they were now clear as to what action they should take if a person fell and when to contact emergency services. We saw people had risk assessments in place that detailed the actions staff should take to minimise identified risks to people and staff we spoke with were knowledgeable about these, for example where a person was at risk of choking. There was however one risk assessment that we found did not fully detail the person's needs in relation to what equipment should be used when they were transferred. The risk assessment referred to assistance given without the use of a hoist. Staff said there were times where they may use the hoist due to the person's variable needs. Staff could tell us which sling they should use to transfer the person so they were safe but this was not documented and there was no formal assessment to confirm that the sling was appropriate for the person. This showed there may be a risk as new staff may not be aware of the person's needs in respect of this element of their care. The registered manager said they would look to put appropriate risk assessments in place.

People who lived at the home said they felt safe. One person told us, "I feel safe as they (staff) are always around asking me if I am alright and are always on the ball.". A second person said, "I feel quite safe here as I am prone to falls and I know that the carers are around to help me safely about so that I am less likely to fall". A third person said, "Safe so far. I came here as my (relative) was worried about me as I keep falling over but since I have been here I haven't fallen over once which makes me feel safe". A relative told us, "Yes I feel that (the person) is safe in the home as they need a frame to get about and have a footpad alarm should (the person) stray out of bed so quite safe in the knowledge (the person) is secure here".

We found the provider's systems for maintaining a good standard of cleanliness needed improvement so people were protected from cross infection. A visiting relative said "(Person's) room is dirty. The skirting board is splashed with tea or coffee stains. There is dirty nebuliser (for use with an inhaler) tissues under the bed, (person) doesn't even have a neb". We did look at the person's bedroom after these comments and found it clean. An infection prevention nurse had audited the service's infection prevention and control in May 2018 and found several areas where improvement was needed though. A number of these issues related to the maintenance of the environment, for example damaged furniture, chipped walls/tiles and damaged flooring that would make effective cleaning difficult. We also saw a number of areas where there were numerous items stored that would make cleaning difficult, such as incontinence pads and dressings in bedrooms. We found some of the works identified by the infection control nurse were yet to be addressed. The provider told us they were working on an action plan and would address the issues identified as a priority, with some action already taken, for example the introduction of red bags for soiled laundry. The home had been rated as generally satisfactory in respect of food hygiene in January 2017. We found the kitchen to be clean and tidy although there was a small area of wall with flaking paint that needed addressing. The provider had identified this as needing action.

People thought staff response to requests for assistance were timely. One person told us, "I have only

pressed the buzzer once but not for me. It was for a lady who I had seen get out of her room. The staff came very fast up the stairs to get to her". Another person said, "I have pressed the buzzer and each time the response was good. I fell once when trying to get the remote to change my TV channel and couldn't reach the buzzer. I had to call and shout out and they came quickly, two of them came rushing in". A third person told us the provider, "Seems to have enough staff around as they are always asking if they can do anything for me". All the people we spoke with echoed the view that there was sufficient staff. We heard mixed views from relatives and staff however. One relative told us, "There always appears to be enough staff and they seem to cope ok" while another relative said the provider, "Have probably got enough but could always do with a few more staff though". Staff felt people were safe but they felt three staff on duty throughout the day would help as with two staff, there was no one present to monitor the lounge area when they were providing care to people in their rooms, plus they needed to carry out non- care duties such as laundry. We saw short periods where there was no staff in the lounge and dining area. Staff said there was some concern some people at high risk of falls may mobilise independently when not supervised. We saw some people did mobilise without calling for staff assistance, and while did appear unsteady at times did manage to walk safely, with one occasion where another person gave assistance by passing their Zimmer frame when staff were not present.

We discussed staffing levels with the provider and registered manager. The provider said they reviewed staffing monthly and made changes to staff deployment based on the findings, for example the provider had already increased the staffing level from two to three on an evening. The provider agreed it was desirable to have continual cover for the lounge area and told us they and the registered manager would work on the rota with care staff during the afternoon to increase staffing levels. Outcomes from the audits the provider had introduced recently did show the number of falls at the home had decreased significantly in the last six months. This indicated that people were safer now, than previously when we had received concerns about numerous falls. The provider was aware that dependency levels had a direct impact on staffing levels and said would continue to keep these under review to keep people safe.

We found the provider's safeguarding and whistleblowing policies reflected local procedures and contained relevant contact information, with related information seen on display in the home. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed abuse or had an allegation of abuse reported to them. The management were fully aware of their responsibility to liaise with the local authority if there were any safeguarding concerns; this demonstrated by alerts that had been raised with the local authority safeguarding team and ourselves. This was also confirmed by information in the provider's information return, sent to us prior to the inspection.

We found a recruitment and selection process was in place that detailed checks needed to confirm a staff member's suitability to work at the home; for example, last employer references, health checks and exploration of their working history. We saw these checks were completed. Staff had been subject to criminal record checks (DBS) before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and help employers to make safer recruitment decisions and prevent unsuitable staff being employed. We did note however one staff member's DBS was seen to have been obtained by their previous employer rather than by the provider. The provider told us they usually obtained a new DBS to comply with their own procedures and recognised this one occasion as an oversight. We confirmed that all other staff had a DBS requested by the provider prior to employment. The provider could demonstrate other checks were undertaken for this staff member and they had worked with other staff until completing their induction.

We found systems were in place to consistently and safely manage people's medicines. One person told us,, "My meds are given to me on time and I can take them myself but they do stop and watch me. I have tablets

with water and also some liquid meds and a throat spray. They do that.". Another person said, "They bring my meds in regularly on time to me. I do my own they just bring them in". We saw staff administering medicines and saw these were given in a safe way, with time taken to explain and reassure people when they took their medicines. We saw medicines, including controlled drugs were stored appropriately and internal audits were completed the last in May 2018. We saw the staff auditing had identified several areas for improvement, and we found action had been taken to address these issues.

Good

# Is the service effective?

## Our findings

We saw staff promoted people's rights, to choose for example, during our inspection. When staff went to assist people, or provide care they always asked the person for their permission and talked to them throughout. When the senior gave people their medicines a choice as to whether they wished to take them was always offered. Staff were aware of the need to respect people's views. A member of staff told us, "People know what they want, you give them choice. A person can change their mind so you offer something different". We saw people were free to move around communal areas as they wished with no restriction.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had made applications for DoLS for several people living at the home but they had only received verbal confirmation, but not written, that two of these applications were to be approved. The provider said they would contact the local authority to ask for formal confirmation of the DoLS and any conditions that may be applicable.

The Provider, registered manager and staff demonstrated a good working understanding of what the MCA meant for their practice, and how they gained people's consent, which we saw staff did consistently throughout the inspection. Staff told us while some people may not be able to verbally communicate their wishes they were conscious of observing their facial expressions and body language and would not carry out personal care unless a person was relaxed and they could assume consent. The staff told us one person was on covert medicines. We saw their 'best interests' had been considered following consultation with the relative, GP and pharmacist. The registered manager told us this process had considered what medicine was essential to maintain their health, what could be discontinued and how best it could be administered, with the medicine changed to liquid form. The management told us how they involved relatives in the decision-making process. We saw evidence that the relatives making decisions on behalf of their loved ones had the appropriate legal powers to make decisions about their health, for instance an agreement giving them lasting power of attorney.

People told us staff were well trained. One person told us, "I have found the staff all to be well trained and they have helped me", A second person said, "The staff are well trained. They know what to do. They all seem very knowledgeable and know my ailments and what I want to do.". A visiting relative told us, "I am pleased with the skills shown. They are all good to [the person's name] and they feel comfortable here". Staff told us there were some areas of their training, for example moving and handling people, in which they had not received an update in over a year, even though our observation of their practice indicated they had appropriate skill and knowledge. The registered manager and provider both said they worked alongside staff to check their competence and if observing any need for improvement would bring this to the staff member's attention. We saw observation of staff was recorded by the registered manger or provider. The provider told us, and had identified staff needed training updates and had changed to a new training provider. The required training modules were due to be rolled out for all staff soon, and we saw evidence of this. The provider said most of the training was video based but they planned to have staff watch in groups

so they could discuss their learning at the same time. They told us moving and handling of people training was the most important and we saw this was scheduled, with some practical elements utilising equipment. Training in other areas of key skills, for example: Dysphasia and dementia care was also said to be planned. Staff recently employed had participated in an induction process that included elements from the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of people working in the care sector.

People told us they liked the food they were offered and had a choice. One person said, "The food is varied. I particularly just like salads and they do that for me. There is also always a choice of puddings and drinks to have". A second person said, "You get a choice to eat. I don't eat meat but have fish, chips, veg, and soup and things like that. I get a choice of drinks and puddings too". A third person told us, "You get a good choice of food and plenty of tea to drink. I have soft food and am diabetic and they cater for that for me". We saw people eating their lunch, and were offered a choice of meals. We saw there was friendly chat between people and staff before meals were served, with staff checking what people had ordered was still what they wanted. People were also asked what they wanted to drink. The cook told us, "I know all of the residents and what food they like or allergies they have" and showed us documented information about people's specific dietary needs; for example, soft and pureed diets. From sight of people's records, we saw that people's diet and fluid intake was monitored. Records confirmed people had a good food and fluid intake. Staff were aware, when people were at risk of choking how to prepare food to ensure this risk was minimised.

Whilst there had been some concerns prior to the inspection in respect of staff contacting emergency services when needed, we saw there had been discussion as to the expected procedure staff should follow in a recent staff meeting. Staff we spoke with were clear if there was any doubt as to a person's health or wellbeing they would call for an ambulance. People told us their routine healthcare was promoted. One person told us, "My daughter does my appointments and I have been out to the hospital for treatment. Having said that staff did organise my prescriptions for me and get them". A second person said, "Staff will do any appointments for me and I do get to see my doctor if required". A third person said, "If I ask to see anyone they will arrange it for me and get a doctor or nurse if I need one". We saw people's contact with people's health care professionals was clearly recorded and showed people were supported to access appropriate healthcare.

The management said they were conscious of people's needs prior to admission and considered if the environment was appropriate to meet these needs, this through what we saw was a suitable pre-assessment process when we reviewed people's care records. We discussed the needs of one person who was in a bedroom on the first floor with the registered manager and provider, who had been unable to use the stair lift when recently discharged from hospital. The provider had completed an assessment and asked staff at the hospital they were in directly as to whether the person could use a stair lift, as they were unable to see them walking. They were told the person could walk and the person had received input from an Occupational Therapist. Despite this the provider found the person was initially unable to use the stair lift on readmission, which contradicted what the provider said they were told at the time of assessment. During the inspection we saw the person's mobility had improved and saw they managed the stair lift with assistance. The provider said they had learnt from this experience and would be more robust in checking the information they were given by other professionals before people were admitted to the home.

We saw the environment was small and homely, although would benefit from some redecoration to assist with infection control measures. People who shared bedrooms confirmed they were happy doing so. We saw there was signage, for example on toilets to help people identify where they were. In addition, people had photos on their bedroom doors, which were of differing bright colours to help with identification. We

also saw pictorial guidance in rooms to assist people with working the emergency call system. We did see a shower, that a relative told us was in use, had a high lip which was a potential tripping hazard if people had to step in. The management told us this shower was not normally in use, and we did see there was a choice of other more suitable bathing facilities.

Good

# Is the service caring?

## Our findings

People told us the staff were caring. One person told us, "The staff are all kind, considerate and friendly. They will always ask how I am and have a natter if they are not doing anything". Another person said, ,; "The staff are all very nice although I do get on better with some than others with their different personalities. They do come in and talk to me which is nice". A third person said, "The staff are all good. They look after me ok and always about to have a chat if I want one". Another person said, "All nice staff, caring and friendly I can't grumble about any of them". This reflected what we saw during the inspection with staff having a kind, caring and considerate approach with people.

People also told us their privacy and dignity was respected. One person told us, "In the short time I have been here my privacy and dignity has been fully respected when helping me to wash". Another person said, "If having a wash down in my room they always close the curtains and the door", A third person said, "They close the door and my curtains and if taking me for a bath do the same there too". We saw staff knocked people's bed doors before entering and one person told us, "They always knock before coming into my room too".

People said they were valued as individuals by staff. One person said, "I have found it fine here. I feel very valued by them all and they have made me feel at home. I have also made a friend and swopped telephone numbers. We had a naughty evening together with chocolate biscuits and the staff left us to it to enjoy". A second person said, "I think they have looked after me well and I am quite content being here". Another person said, "I have been here a while now and the staff are all good and value me". We saw staff spoke with people in a way that showed respect with use of their preferred names and spending time with people to listen to what they had to say. We also saw staff were happy and this reflected on people, whom we saw were laughing with the staff on numerous occasions.

We saw staff consistently offered people choice and ensured their consent before; for example, providing personal care or support. Staff told us they would ask everyone for their choices. Where they were not able to verbally communicate they would look for non-verbal signs of the person's agreement/disagreement before proceeding, as we saw when observing staff interactions. One staff member told us, "People know what they want, you give choice".

We saw people were encouraged to maintain their independence where ever possible. One person told us "I go out into the garden area and keep moving about". Another person said, "They (staff) have encouraged me to keep moving my shoulder and arm to make it better more quickly". We saw those people who were able, move around the home as they wished, and those less able were encouraged by staff to walk with assistance.

People told us there was no restriction on their friends or relatives visiting the home. We saw people visiting were greeted in a friendly way on arrival. One person told us, "My daughter comes in regularly and there are no time restrictions as to when she can come", another person that, "My friend comes in regularly to see me and also two other friends of hers that bring their little dog in to see me which I like to see very much. They

can come in at any time". A third person ,said, "My daughter and family visit. There are no restrictions as to when they can come in".

No one was using advocacy services at the time of the inspection although when we asked the registered manager she said if a person needed support with any issues they would use local advocacy services to gain this support for them.

Good

# Is the service responsive?

## Our findings

People and their representatives were involved in their care plans. One person told us, "My daughter did my care plan for me. I know I do have one". Another person said, "My [relative name] sorted all that out for me and also coming here". ,A third person told us., "Yes they do it [care planning] here and I have full input into it as well". One person told us, "I don't know who did my care plan. I have a friend who comes in and does most things for me as I have no family so perhaps she did it". They were however unconcerned as regardless of whether there was a care plan, they said staff knew their needs well and provided care as they wanted it. Where people's relatives or friends had consented on their behalf people did confirm this was with their agreement and prior knowledge. A relative told us staff wrote a care plan for their loved one as soon as they moved into the home, and they were involved. The provider told us in their provider information return (PIR) submitted prior to our inspection that they tried to gather as much information as possible about people prior to admission, including that gained from people, relatives and previous care settings they may have used.

We reviewed people's assessments and care plans. We found these were detailed and contained information about people's likes and dislikes. When we spoke with staff we found they had a good understanding of what was important for people. We saw there was regular reviews and care plans were updated when any changes were observed. One person told us, "Staff know all my likes and dislikes too", another person that, "The staff are all good and trained I think. They know my likes and things and they know I like to watch the football and cricket on TV". A third person said staff, "Have got to know me well, always on first name terms and know I like particular food".

We found people's care plans covered information staff needed to know so that they knew what was important when providing person centred care, for example care plans reflected what was important for people, their preferences, choices as well as health needs. Staff we spoke with had a good knowledge of people's needs which reflected people's care plans. The provider told us in their PIR they considered people's dementia and history to look at ways in which they could communicate better, for example they told us about a person who had served in the army and found addressing them by the term sir was agreeable to them. In addition, we saw the provider had considered how to assist people to use the call buzzers by displaying pictorial signs explaining how they worked in each bedroom. The staff team was all female, but none of the people living at the home had any objection to receiving care from female staff, as opposed to male.

People told us they could follow past times they enjoyed. One person told us, "There is always something on for everyone to do and they have also supported me with giving me painting sets and books to read.". A second person said,, "They help me read and to give me knitting things and word searches and puzzles. They have activities on but I prefer not to join in. I am happier in my room doing these things with my TV". A third person commented, "Staff help me join in with things that they arrange and they know I like my football cricket and rugby on the TV to watch. The activities are a bit varied and I do join in as much as I can".

We saw there was a daily activities programme on display in the main hallway and we saw the activities planned did take place. This was displayed in an accessible format that used pictures and writing. For example, there was an external exercise man that visited on the first day of inspection. We saw people were thoroughly enjoying this session, and were singing and dancing. We saw some people living with dementia showed clear signs of stimulation and enjoyment. In the afternoon we saw a planned resident's meeting took place in the lounge. We asked the provider how people who chose not to come to the lounge were involved and they said they would discuss the agenda with people on a one to one basis. The provider had considered people's religious needs and people visited the home from churches on occasion. One person visited church with their family. The provider was also aware of the specific requirements people may have in respect of their health care based on their specific religion.

We saw there was a complaints procedure on display in people's bedrooms and communal areas. We saw people were also asked if they had any concerns as we saw during a 'residents meeting'. Staff told us they would observe people's behaviour and expressions to monitor their views. People we spoke with mostly said they had no complaints, although said they would be able to raise any concerns if needed. One person told us, "I would speak to my carer when she comes around" and second person that, "Speak to [staff name] who is the senior carer. A relative said, "I would go straight to them (managers)". They told us that there had been issue that week with their loved one's jumpers 'ruined' in the wash and said they had raised this with the provider. The provider told us they were aware of this recent concern and would identify why this had happened and look to recompense the person. The relative said anything they queried with staff lead to an appropriate response they were satisfied with. We looked at the provider's complaints records and saw these were monitored with all comments recorded included minor verbal concerns. We saw the response to these was fully documented. We saw there was only one recent formal complaint and this had been resolved following investigation.

We found the registered manager and provider had considered the need for improving how the service responded to people's end of life care. They had consulted with people and their representatives and were in the process of developing end of life care plan formats in conjunction with support from an end of life specialist from a Hospice. We spoke with this professional who confirmed staff were to have training in end of life care and they were auditing the service's progress. They told us the management and staff had really engaged with them and felt the staff were making progress in this area. From sampling people's care files, we saw the staff were completing end of life care plans that would make clear what people's wishes were for any future period where they may not be able to express these.

Requires Improvement

# Is the service well-led?

## Our findings

People told us the service was well managed. One person said, "It has been like a second home being here. No 'can I have this or that', so easy going" and another person told us, "They look after me well". A third person said, "I'm perfectly happy here". A relative told us, "From what I have seen yes I do. I am happy [person's name] is here and [person's name] is happy too". Most people told us they knew the registered manager with a few exceptions with comment from a person that, "She is smashing and very approachable". A relative told us the registered manager was," Very helpful."

We had received some concerns from the local authority prior to the inspection in respect of the high number of falls at the home. We were told it was unclear from information the local authority received as to whether staff knew what procedure to follow when someone had an injury, this to ensure this was consistent and people received timely and appropriate emergency healthcare. We spoke with the registered manager, provider and staff as to their understanding of what action they should take if a person fell and was injured and they were all consistent in their responses, in that if there was any doubt as to a person's wellbeing they would call 111. The provider showed us how they had revised their audits so that any trends in respect of falls or accidents would be easier to identify and respond to. We also saw the number of accidents since the concerns were raised looked to have decreased. The provider and registered manager were also very clear they would not accept people whose needs could not be met, for example people with behaviours that may challenge staff or unable to use the stair lift. The provider told us while they had reassessed a recent re admission from hospital they had learnt, due to the person's needs not reflecting what they were told, that they needed to be more robust in corroborating evidence from assessments.

We looked at other audits that were in place and found most of these identified trends and areas for improvement; for example, we saw the internal medicine audit had identified a number of issues and we found that these issues had been addressed. The most recent infection control audit carried out by staff had not identified any issues or improvements needed in respect of infection control. A visit shortly after by an infection control nurse did identify numerous areas where the provider needed to make improvement to the environment and equipment. This indicated the provider's internal infection control audits needed to be more robust. The provider had taken some action to address these improvements but these were not complete. The action plan requested by the infection control nurse was still to be completed at the time of the inspection, although we did note the return date for this plan was not due at the time of the inspection. The provider told us they would complete this action plan and a refurbishment plan for the environment as well.

We asked people how they could share their views about what they thought of the service they received and they told us they could talk to staff and had meetings with the provider, one which took place during the inspection. People we spoke to were aware this was taking place. People told us if they were not attending the meeting the registered manager or provider would come and discuss the agenda with them individually. One person told us, "I have been down to one resident's meeting but they do come and ask me about things in my room". A second person said, "We do have meetings every so often. I think there is one today as it happens. They do ask what we want". A third person said, "I don't go to resident's meetings as they hold

them downstairs but they do come in with a list and keep me informed and ask if I want to input anything". We also saw the provider sent out survey forms to people and their relatives and we saw the collated findings had been displayed on the notice board in the home. This indicated that people were overall satisfied apart from some concerns as to laundry and some relatives wishing to be better informed. From discussion with relatives we found they felt better informed and we saw there was now records of contact with relatives in care files. The provider told us they were now ensuring relatives were informed of any changes. The provider was open that there were still occasional issues with laundry and they were trying to resolve these.

Staff we spoke with told us they were well supported and thought the home was well led. They said they enjoyed working at the home. One member of staff told us, "It is a lovely little place to work. With the home being small it is more personalised and I know all the residents". Another member of staff said, "I get full support from the manager and we all work well as a team. I love it here. I would say it was small, personalised and very well run". We saw the provider had introduced staff survey forms and the ones we saw showed overall staff were satisfied with the support they received with only comments related to areas of improvement, 'more one to one care' and, 'not enough of us to deal with everything at times'. The provider told us they had introduced a staffing tool based on dependency and reviewed/made changes to staffing as appropriate every month. Staff told us they had recently received supervision and felt well supported by senior staff and the acting manager. Staff told us they had one to one sessions with either the provider or the registered manager and said they felt well supported. One member of staff said, "Any problems I can talk to the management, they are approachable" another said, "The management are supportive and if I need any training I get it, I am currently doing my NVQ level 3". We saw some updates in training such as moving and handling were overdue however, this said by the provider to be due to the change of training provider, with training now seen to be scheduled.

Staff we spoke with were aware of the provider's whistleblowing policy and said they felt able, and would raise any concerns about safety with external organisations should this be needed.

The provider and registered manager said they would be open and honest as required under their duty of candour, and we saw evidence that they had instigated discussions with people and relatives in respect of changes. They acknowledged that relatives had asked to be better informed in the last survey and were committed to ensuring they addressed this wish. They were open about the challenges they felt the service faced, maintaining safe staffing levels and sourcing a new staff training provider so that staff training could be updated. We also saw they understood the need to notify us of incidents that may occur, these having been sent to us promptly as required. The law requires the provider to display the rating for the service as detailed in CQC reports and we saw the rating for the service as given following our last inspection was clearly on display in the home. The provider does not currently have a website for display of the ratings.

The provider told us in their provider information return (PIR) before the inspection that they worked in partnership with other agencies, this including for example GPs, nurses and opticians. We spoke with a visiting health care professional who confirmed they were responsive to their advice and they were aware that the service had, "Regular support from the local GP Practice". The provider also told us that advice from the local authority following their last visit had been helpful and they, as we saw, were taking on board comments that had been made to improve the service. We saw the provider had taken this advice to develop systems for better self-audit of the service, although there was scope to continue developing these.