

# Wilton Rest Homes Limited

## Beacon House

### 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 caring?          | Good ●                 |
| Is the service responsive?      | Good ●                 |
| Is the service well-led?        | Good ●                 |

# Summary of findings

## Overall summary

The inspection took place on 09 and 10 July 2018 and was unannounced. Beacon House 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. Beacon House accommodates up to 23 people in one adapted building. At the time of the inspection 13 people were accommodated. The service also has seven bungalows on site but at the time of our inspection, no one living in the bungalows either required or was being provided with the regulated activity of personal care.

Since the last inspection a new manager had been appointed who had registered for the regulated activity of personal care and accommodation. Following this inspection, the registered manager has also applied to register for the regulated activity of personal care so they could provide this care to people living in the bungalows if required. 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.

At the last inspection in December 2017 we identified two continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two new breaches. The service remained in special measures and we met with the provider to confirm what they would do and by when to improve the key questions of safe, effective and well-led to at least good. At this inspection we found the requirements of these regulations had been met, four of the key questions have now been rated as good and safe has been rated as requires improvement with no breaches of regulations. Safe recruitment practices had been followed and relevant action was taken during the inspection to ensure long-standing staff updated their Disclosure and Barring Service checks. The premises and equipment had been regularly maintained and checked to ensure they were safe for people's use. Audits and surveys were now effective and where issues had been identified action had been taken to address them for people and to drive service improvements. The registered manager understood what they were required to report and had ensured relevant notifications were submitted.

This service has been in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall. Therefore, this service is now out of special measures. The provider has continued to work with CQC within the terms of their existing voluntary agreement to ensure that all new admissions have first been reviewed and agreed by CQC.

Risks to people had been identified and managed safely. The registered manager acted during the inspection to introduce a falls risk assessment to enable them to be able to demonstrate consistency in how they assessed falls risks to people. They were acting to ensure people's risk assessments were reviewed

monthly as described in their care plans. These actions still need to be embedded in staff's practice.

Staff had undertaken relevant training to enable them to safeguard people from the risk of abuse. There were adequate numbers of staff to provide people's care. People received their medicines safely from trained and competent staff who followed the medicines guidance provided. The service was visibly clean and staff followed the infection control guidance provided. Processes were in place to ensure learning took place following incidents.

The registered manager has ensured that staff have access to relevant good practice guidance. Staff reported they felt well supported in their role, through the processes of induction, training, supervision and appraisal provided for them.

People were provided with a choice of meals and enjoyed their eating experience. People were monitored to ensure they did not become malnourished or dehydrated. Processes were in place to ensure people's healthcare needs were met and the effective sharing of information when they transferred between services. A programme of refurbishment of the service was underway.

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

Staff were kind and caring to people. They knew them well and showed an interest in their welfare and comfort. People were asked for their views about their care and their choices and decisions were respected. Staff were heard to speak to people in a respectful manner. People's privacy and dignity were upheld during the provision of their care. Staff ensured that people could be as independent as they wished.

People told us the service was responsive and that staff understood their needs. Staff had a good understanding of people's care needs. The registered manager was in the process of making improvements to people's care plans, but the process still needed to be completed and embedded. People were provided with a varied range of both internal and external activities for their stimulation. People were provided with details of how to make a complaint if they wished.

Staff had undertaken end of life care training and the provider had already identified that further work was required to ensure all new people had been consulted about their end of life wishes.

There was a positive culture within the service that was person centred and open. Processes were in place to enable people, their relatives and staff to express their views on the service and these were listened to and acted upon. The service was looking outwards and making links locally to support staff in their role. Staff worked in co-operation with a range of services and professionals in the provision of people's care.

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

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe.

The provider had systems, processes and practices in place to safeguard people from the risk of abuse.

The provider followed safe practices when recruiting staff. They had taken relevant action to ensure long-standing staff were required to update their Disclosure and Barring Service checks periodically.

Risks to people had been identified and managed safely. Further work was underway to ensure consistency in the assessment of people's falls risks and to ensure all risk assessments were reviewed monthly.

There were sufficient staff deployed to meet people's needs.

People's medicines were managed and administered safely.

People were protected from the risk of acquiring an infection.

Processes were in place to ensure learning took place following incidents.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

People's needs were assessed and their care and treatment was delivered in line with current legislation and good practice guidance.

The provider had processes in place to ensure staff had the skills and knowledge required to provide people's care effectively and that they were supported in their role.

People were supported by staff to eat and drink sufficient for their needs.

Staff worked together to deliver effective care, support and treatment.

**Good** ●

People were supported by staff to access healthcare services.

The provider was refurbishing the service to ensure it was maintained and met the needs of people who used the service.

### **Is the service caring?**

**Good** ●

The service was caring.

People were treated with kindness, respect and compassion.

People were asked for their views and they were actively involved in decisions about their care.

People's privacy, dignity and independence were respected and promoted during the delivery of their personal care.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People received personalised care that was responsive to their individual needs.

People were provided with a varied range of both internal and external activities.

Processes were in place to enable people to make a complaint where required.

Work was underway to ensure people were consulted about their end of life wishes.

### **Is the service well-led?**

**Good** ●

The service was well-led.

There was a positive culture within the service that was person centred and open.

The registered manager understood what they were required to report and ensured relevant notifications had been submitted.

People, their relatives and staff were engaged and involved with the service.

Processes were in place and used effectively to evaluate and improve the quality of the service provided.

The service worked in partnership with other agencies in the provision of people's care.

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# Beacon House

## Detailed findings

### Background to this inspection

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

The inspection took place on 09 and 10 July 2018 and was unannounced. The inspection was completed by one adult social care 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. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

Prior to the inspection we spoke with or received written feedback on the service from professionals who had recently been involved with the service including: two nurses and an environmental health officer. During the inspection, we spoke with six people and two relatives. We spoke with four care staff, including night care staff, chef, activities co-ordinator, deputy manager and the registered manager.

We reviewed records, which included four people's care plans, four staff recruitment and supervision records, and records relating to the management of the service.

The service was last inspected in December 2017 when it was rated requires improvement overall and remained in special measures.

## Is the service safe?

### Our findings

People told us they felt safe living at the service. A person told us, "I feel safe, they look after me very well" and a relative commented, "I feel [loved one] is quite safe here. [Loved one] knows everyone and has a good relationship with the staff." People told us risks to them were well managed, a person said, "I have a special mat in case I fall." Most people felt there were sufficient staff and noted that there had been a recent increase in staffing. People felt their medicines were well managed and that the environment was clean.

At our previous inspection in December 2017, we found the registered provider had failed to protect people by ensuring that all the evidence required within Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been obtained for all staff as required. This was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider had failed to ensure all aspects of the premises met health and safety legal requirements. This was a new breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we met with the provider and they produced an action plan which stated they would meet the requirements of Regulation 19 by 28 February 2018 and the requirements of Regulation 15 by 31 June 2018. At this inspection we found the provider had completed the actions in their action plan and both regulations had been met.

Staff files for new staff recruited since the last inspection contained evidence of all of the required pre-employment checks. This included a full employment history, proof of the applicant's identity, references, fitness to work and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had ensured that all long-standing staff had also provided their full employment history. References for long-standing staff had been followed up and obtained where possible. We identified that some of the long-standing staff's DBS checks were completed some years ago. We spoke to the registered manager who had also noted this. Although there is not a time limit on the validity of a DBS check, it is good practice for providers to set a period of how often they should be renewed. The registered manager informed us they had identified which staff this affected and planned to require staff to update their DBS checks every five years. They acted during the inspection and submitted these applications, to ensure these had been renewed.

The provider had ensured relevant safety checks had been completed as required in relation to fire, electrical, gas, water and equipment safety. Since the last inspection the light fittings in the bathrooms had been replaced to ensure they now conformed to legal requirements. Relevant windows had either been fitted with safety film or replaced to ensure they now met safety standards. A programme was also underway to upgrade the service's existing thermostatic mixing valves (TMV). A TMV is a mechanical valve that mixes hot water with cold water to provide a safe, controlled hot water outlet temperature, to protect people from being scalded.

Staff had completed face to face safeguarding training which they updated annually. Staff spoken with understood the signs that might indicate a person had been abused and their duty to report any concerns.

There was evidence staff had been required to read the safeguarding guidance provided and had signed to demonstrate they had read and understood it. Staff had access to relevant safeguarding guidance and contact numbers if required to enable them to protect people. The registered manager understood their role should a concern be raised and since the last inspection had sent two safeguarding alerts to the local authority. People were safe from the risk of abuse.

Risks to people from their skin breaking down had been assessed. Daily checks were made upon people's skin integrity and those at risk of their skin breaking down due to their immobility were re-positioned regularly in accordance with the guidance in their care plans. People were provided with pressure relieving equipment as required and daily checks were made upon the functioning of air mattresses where provided for people's safety.

Risks to people in relation to moving and handling had been assessed. The registered manager was a qualified staff trainer in manual handling and records showed staff were up to date with this training. Staff were observed to transfer a person safely using relevant equipment, as described in their care plans. Staff could describe the safety checks they completed prior to moving people, to ensure people's safety.

People were provided with relevant equipment to manage the risk of them falling, such as sensor mats to alert staff when people moved and call pendants to summon assistance. There was guidance in people's care plans about how to minimise the risk of them falling. If people fell, staff followed the post-falls protocol to monitor people's welfare. We noted that risks to people from falling had been identified from their initial assessments and commissioner's assessments and measures taken to manage any risks, which were then reviewed following any falls. However, there was not a falls risk assessment on people's records, as required by the provider's falls prevention policy. A falls risk assessment form, reviewed monthly, would have enabled the provider to be able to demonstrate how the risks to people from falling were consistently assessed. We brought this to the registered manager's attention who took immediate action to source and complete a falls risk form for each person. It will take time for them to be able to demonstrate the use of this has become embedded in staff's practice.

We also noted that not all people's skin integrity, and moving and handling risk assessments had been reviewed monthly, to ensure regular monitoring. Some had not been reviewed since April 2018. We brought this to the registered manager's attention. They informed us that they were aware that senior staff had struggled to review all care plans including risk assessments as everyone's care plans were also in the process of being re-written. They were introducing a keyworker system to address this for people so that staff would then not be responsible for updating more than two to three care plans each per month. The registered manager was aware of this issue and was acting to address this for people, but it will take time to demonstrate the effectiveness of the new system.

People and staff felt there were sufficient staff overall to meet people's care needs. The registered manager had introduced a staffing dependency tool to be able to evidence how adequate staffing levels for the service had been calculated. There was some use of agency staff and both the registered manager and the deputy manager worked on the floor as required to ensure any gaps in the staffing roster were filled. An additional senior care worker had been recruited and was due to start work shortly. There were two vacancies for night staff. The registered manager tried to ensure there was always a permanent member of staff on night duty, but if there were two agency staff rostered then either they or another member of staff remained on-site to administer people's medicines and to be available if required.

People received their medicines safely from trained staff whose competency to administer their medicines was regularly assessed. Processes were in place to ensure people's medicines were ordered, stored,

administered and disposed of safely. Arrangements were in place to ensure the safe storage of 'controlled drugs' which require a higher level of security. If people required topical medicines for their skin, these were dated when opened to ensure they remained safe for use. There was guidance for staff with regards to medicines people took 'as required'. The administration of all medicines, drops and creams was documented on a medicine administration record (MAR). We saw people's MAR sheets were complete without gaps and these were checked daily. Staff were required to read and sign the medicines policy, which had a date by which it was to be reviewed, to ensure it remained current.

Staff had undertaken infection control training and relevant staff had undertaken food hygiene training. Staff wore the personal protective equipment provided when supporting people with care and serving their meals. The service was visibly clean and we observed staff carried out cleaning of the service. Those bathrooms which had a separate toilet were now fitted with a hand gel dispenser that people could use to cleanse their hands. People who were hoisted had their own sling to minimise the risk of cross-infection.

Staff had been reminded of the importance of reporting any issues at the staff meeting held on 11 April 2018. Those staff spoken with understood the importance of reporting any issues they identified for people's safety. Where incidents had occurred such as falls, an incident form had been completed and any relevant actions identified and taken to reduce the risk of repetition for the person. Any changes to people's care due to new or emerging risks were discussed at the staff shift handover, to ensure they could be managed for people.

## Is the service effective?

### Our findings

People told us the service was effective. People said they had been involved with their care planning. A relative told us, "Staff are well trained." Another relative said, "[Loved one] had a full assessment recently. [Loved one] is no longer mobile and they have got [loved one] a new bed which has eliminated any issues with falls. It was fully discussed with me." People said the quality of meals was good and their health care needs were met.

On 7 October 2016, the provider entered into a voluntary agreement not to admit anyone new to the service without the prior written agreement of CQC and this agreement has remained in place since. Following the last inspection six people had been admitted to the service up to the date of this inspection, either on respite care or a permanent basis, with the agreement of CQC. The registered manager has demonstrated a good understanding of the specific needs of each new person admitted to the service and ensured that adequate staff numbers, with the right skills and experience, were in place prior to these admissions. Records demonstrated each new person's needs had been assessed prior to their admission.

The registered manager had ensured that staff have access to best practice guidance, in relation to areas such as: medicines, wounds, use of bed rails and food safety. Staff had been attending local best practice forums and the provider had joined the local care association in addition to subscribing to email updates from CQC, to ensure staff receive relevant updates.

New staff told us they had received an induction to their role, they were also allocated a more senior member of staff to 'buddy' them, to ensure they felt supported. Records showed that eight of the nine care staff held a professional qualification in social care. Those staff that did not have a background in social care were required to undertake the 'Care Certificate' which is the industry sector standard induction for care staff. All staff were required to undertake a range of required training, in addition to training relevant to the needs of the people supported. For example, some staff had undertaken glucometer training to enable them to undertake blood sugar monitoring for people living with diabetes. Staff told us they had been provided with information sheets to provide them with guidance in relation to other conditions people lived with in order to develop their understanding. The staff training programme was ongoing and we saw that a range of training had already been booked for staff to attend across the remainder of the year. Records demonstrated staff received a total of four supervisions across the course of the year, which included an annual appraisal of their work. This enabled staff to reflect upon their work over the past year and to identify their learning needs for the coming year. Staff reported they felt well supported.

People were weighed monthly and their risk of experiencing malnutrition was assessed. Although no-one was currently at risk of malnutrition, the chef could tell us how they would fortify people's meals if required to increase their weight. People were served hot drinks across the course of the inspection and had access to cold drinks. Although no-one was dehydrated, staff understood the risks with the hot weather and were monitoring the intake of those identified as most at risk.

People were provided with a choice of what they wanted for breakfast and could have a cooked breakfast if

required. At lunchtime there was a choice of two hot meals. The chef told us they could always provide for vegetarians or provide an alternative meal if people did not want what was on the menu. There was also a choice for supper and staff had 24-hour access to the kitchen to make people snacks at night if needed.

We observed that the lunch service, although slow in starting on the first day of the inspection was a pleasant and sociable experience for people. It was not rushed and people were able to eat at their pace. If people required adapted cutlery or crockery to promote their independence then these were provided. Most people chose to sit together and chatted both between themselves and with staff as they ate their lunch.

Processes were in place to ensure staff shared information across the service through the shift handovers. When people joined the service or returned from hospital, staff ensured they obtained copies of assessments from other agencies and discharge letters, to ensure the person received effective care. We observed staff arranging an urgent medical appointment for a person. They completed the Situation, Background, Assessment, Recommendation (SBAR) tool. This is a recognised communication tool for the effective exchange of important information between services. Staff worked together to ensure people received effective care when they moved between services.

People felt their health care needs were well met. A relative told us, "Dentist comes in. Staff arranged for [loved ones] ears to be syringed. They went the extra mile when the hospital didn't have enough staff to bring [loved one] back, they arranged everything." The registered manager told us people could register with a GP of their choosing. If people required support to attend appointments then staff would book a taxi and accompany them. In addition, a community nurse ran a monthly clinic at the service to review the care of people whom staff identified as at increased risk. People were supported by staff to access healthcare services.

Since the last inspection the provider had commenced a programme of refurbishment encompassing both the main house and the gardens. The chair lift to the third floor had been inspected since the last inspection and certified as working and safe. During the inspection we saw that the main hallway, stairs and first floor landing were being redecorated. This was to be followed by the redecoration of the annex, the lounge and people's bedrooms. The registered manager told us that as most people living with dementia were accommodated in the annex, the plan was to paint people's bedroom and bathroom doors the same colour to aid their recognition and orientation. Work had also commenced on the garden, with the replacement of garden furniture and an area of the garden had been fenced off ready to create an area for people who required access to a 'secure' garden, for use once a disused fire escape had been removed. The plan was to create a 'sensory' garden in this space to stimulate the senses of people with dementia or a visual impairment, with raised beds which people could also access from a wheelchair. The environment was being refurbished to better meet people's needs.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. 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 were being met and found they were.

Staff had undertaken MCA and Deprivation of Liberty Safeguards training and understood their application

to their role. They were aware of who was subject to Deprivation of Liberty Safeguards and the restrictions in place. Deprivation of Liberty Safeguards applications had been underpinned by a MCA assessment to demonstrate the person lacked the capacity to consent to their care and treatment and the restrictions in place upon their liberty. Where people had the capacity to consent to the care they received they had signed their consent to demonstrate they had been asked. Where people had appointed a power of attorney to make decisions on their behalf in the event they lacked capacity to make decisions about either their finances or health and welfare. Then a copy had been requested, so staff could assure themselves of the decisions the donor was authorised to make.

## Is the service caring?

### Our findings

People told us staff were good, they treated them well, involved them in decisions about their care and upheld their privacy and dignity. Their comments included, "They treat me very well indeed." "They all know me very well." "They always ask without exception, everything is explained." "They [staff] will knock/call out before they come in to my room. Visitors are made to feel very welcome." A relative said, "The staff communicate with [loved one] and I very well. They have regular agency staff who know the residents."

People were observed to enjoy warm and caring relationships with the staff. We saw staff greeting and chatting to people about their weekend. Staff had a good understanding of each person and used this knowledge to interact with them. For example, a person was keen on a specific sport. Staff could be heard chatting to the person about this interest and we noted the person's bedroom reflected their interest. A nurse confirmed to us staff were kind and caring.

Staff took the time to explain to people what they were doing and why in relation to their care. They provided people with reassurance about when they would help them if they could not do so immediately. At lunchtime staff ensured people were seated together unless they preferred their own company to ensure they could chat and enjoy a sociable lunch. Staff knew who people preferred to spend their time with, and where, and what calmed them if they became agitated.

The registered manager told us staff received a briefing on new people, prior to their admission. A person told us, "They [staff] understand my needs and preferences." Staff could tell us about people's personal backgrounds, including that of people accommodated for respite or who were new to the service. Staff had time for people, a person wanted to play a board game and we saw that the activity co-ordinator made time to do this with the person.

The registered manager told us they asked people how they liked to live and their daily schedule at their initial assessment. We heard at the f shift handover staff discussed that a person had gone to bed late as they had been watching a programme of interest to them. Another person was finding it very hot at night, so staff had discussed with them if they wanted their bedroom door to be left open. On the second day of the inspection staff delayed lunch as people wanted to watch the broadcast of the RAF's centenary fly pass. People's choices were sought and respected.

People were asked for their views about their care. Staff told us, "We always ask permission for everything we do" and "We must ask if they [people] are ready to receive care." We heard staff asking a person if they wanted their breakfast or their personal care provided first. Staff also explained how they involved people in decisions about their care by showing them the options if they did not understand.

Staff were heard to speak to people in a respectful manner using their preferred term of address which was noted in their care records. A person told us, "They respect my privacy." People were asked if they preferred their care to be provided by male or female staff. If people required additional privacy when their family visited or for aspects of their care delivery this was noted for staff's information. Care staff were observed to

knock on people's bedroom doors and await a response before entering. Staff could describe how they upheld people's privacy and dignity during the provision of their personal care. The registered manager, the senior care staff and the deputy worked on the floor with care staff as required, which enabled them to have regular oversight of how staff approached people and upheld their privacy and dignity.

Staff ensured that people could be as independent as they wished. People's care records noted what they could do for themselves. We saw people went to their bathrooms to complete their own self care where they could. Staff promoted people's right to be independent.

## Is the service responsive?

### Our findings

People told us the service was responsive and that staff understood their needs. A relative said, "They do understand [loved ones] needs and respect [loved ones] decisions. Most people felt there were sufficient activities provided that were of interest to them. A person told us, "There are frequent outings organised and I do go shopping with friends, family members. There are quite a few activities that go on daily, if one wishes to get involved." A relative said, "When there has been any review it is discussed with me." Most people had not had cause to make a complaint, but felt any complaints they made would be addressed.

The registered manager informed us that they had introduced a new electronic care plan format to replace their hand-written ones and people's care plans were in the process of being re-written. They were doing this to ensure clarity of people's records and to enable them to be updated more easily. This had resulted in a slight delay to some of the monthly care plan reviews. However, the registered manager confirmed that they and the staff were aware of no changes which had occurred to people's care needs since their last review. It was evident this work would be completed by the end of July 2018. Ready to discuss with people and their relatives at the next residents and relatives meeting how they would be reviewed through the new keyworker system. The registered manager was in the process of changing people's care plan format and had a clear plan of when this would be completed and was rolling out the new keyworker system.

We also noted that for two people admitted recently, their, 'All about me' and 'My life' documents were empty as was their 'Person centred profile'. We spoke to the registered manager who was able to demonstrate that a member of staff had been allocated to complete this work, which was underway for people.

People's new care plans outlined their abilities in relation to the care they required, the outcomes the individual wished to achieve and what support they required. Their care plans stated how they wanted their care provided. For example, how a person liked their tea. A person liked to have their breakfast in their bedroom and we saw this was where it was served. People's care plans reflected their wishes about how their care was to be provided.

Staff received an update about people's care needs and any changes at each staff shift. In addition to reading people's care plans, they could access information about people's care from the person's 'support plan in brief,' which provided key information about the person and their care needs and any associated risks.

The service ensured that people had access to the information they needed in a way they could understand and is complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager provided examples of where people had been provided information in a format that met their needs. For example, the activities schedule was presented in a pictorial format to enable all people to read it and each person was provided with a copy.

People were provided with a range of internal activities. These included: exercises, games, one to ones, communion, the service 'shop', films, music, reminiscence, coffee mornings and time in the garden. The provider could hire transport suitable for people's needs, including those who used wheelchairs and a trip to a zoo was due to take place shortly. The activities co-ordinator maintained a record of the activities people had participated in, which demonstrated the amount of stimulation people had received.

People were provided with a copy of the complaints process when they moved into the service. There was also a suggestion box for people to place any ideas in. No written complaints had been received since the last inspection. A person told us they had raised an issue verbally. The registered manager could tell us the action they took to address the issue for the person, but it is good practice to document verbal as well as written complaints and how these have been addressed for people. This has been brought to the registered manager's attention for their consideration.

Nine staff had completed end of life care training, to ensure they had the skills and knowledge to support people at this time. No-one was receiving end of life care at the time of the inspection. However only one person's records reviewed contained an end of life care plan to outline their wishes and preferences at the end of their life. The provider had already identified this issue from their own auditing processes and an action had already been identified to complete these with people where they were ready to by the end of August 2018 and this work was underway.

## Is the service well-led?

### Our findings

People told us the service was well-led. A person said, "Whatever I ask about is dealt with." Another person said, "If you are not able to live in your own home, then this is the next best thing." "We have resident's meetings, they keep us informed." A relative commented, "Its homely and well run." Another relative informed us, "It's a partnership here."

At our previous inspection in December 2017, we found the registered provider had failed to operate fully robust and effective systems to assess, monitor and improve the quality of the service provided. This was a continuing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider had failed to notify CQC of all safeguarding notifications they had submitted to the local authority. This was a new breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following the inspection, we met with the provider and they produced an action plan which stated they would meet the requirements of Regulation 17 by 28 February 2018 and the requirements of Regulation 18 by 2 February 2018. At this inspection we found the provider had completed the actions in their action plan and both regulations had been met.

A range of audits of the service had been completed based on The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to monitor the quality of the service provided and to identify areas for improvement. People's medicines had been audited monthly and actions taken when issues were identified. For example, in the January 2018 medicines audit the need to update people's medicines lists was identified and this was completed by 29 March 2018. In the June 2018 audit it was identified that a method was required to ensure the medicines storage room did not get too hot and an air conditioner was supplied and fitted on 6 July 2018 to ensure people's medicines were stored at the correct temperature. The dignity and respect audit completed in May 2018 identified staff needed information on protected characteristics as defined by the Equality Act 2010, these were provided on 29 June 2018 to develop staff's understanding. The staffing audit of April 2018 identified the need to introduce a staffing dependency tool and this was done on 27 June 2018. People's falls were audited monthly in relation to: the place of the fall, the time, any injury, hospitalisation, who was informed and if the falls protocol was followed, to identify any trends.

The registered manager had used their service improvement plan to report their progress to CQC on the issues raised at the last inspection as required as a condition of their registration. They had also used it to identify for themselves areas of the service for improvement. They had added a further 12 actions of their own to the service improvement plan, some of which had been completed, such as replacing some areas of carpeting and some which were underway such as the upgrading of the thermostatic mixing valves, to ensure people were protected from the risk of scalding. The registered manager has demonstrated a proactive approach to driving improvements in the service, as opposed to waiting to be told what areas require attention.

A residents' survey had been sent out in April 2018 and six people returned their form. Overall people were very satisfied. Records showed that where people had raised issues in their feedback. The registered

manager had taken the relevant action and provided feedback on the actions taken, both to the individuals who had raised the issues and to residents and relatives collectively at their last meeting held on 29 May 2018. Audits and surveys were now effective and where issues had been identified action had been taken to address them for people.

Since the last inspection two notifiable incidents had been correctly reported to CQC. The registered manager understood what they were required to report and ensured relevant notifications had been submitted.

The provider's aims were set out in their statement of purpose. They aimed to provide people with a high standard of care in a relaxed and happy environment. Staff told us there was a good working atmosphere. A staff member said, "I enjoy coming to work" and the, "New manager is helpful, resolves issues." Another staff member said, "If I ask for something it is ordered. I feel listened to." Staff felt positive about their work and were happy to work in the organisation. Since the last inspection the registered manager had created a new, more comfortable staff room for staff to take their breaks in, recognising staff's needs. There was culture of openness when things went wrong. We saw evidence relatives had been informed when people experienced an incident such as a fall. The registered manager and the deputy were visible on the floor, regularly working shifts alongside staff, to enable them to monitor the culture and staff's working practices. There was a positive culture within the service that was person centred and open.

Following the last inspection, a new manager had been appointed and they had registered for the regulated activity of personal care and accommodation. Following the inspection, they also applied to register for the regulated activity of personal care so they could provide this care to people living in the bungalows if required. Staff understood what was required of them and records demonstrated they had been required to read and understand the relevant policies that underpinned how people's care was to be provided.

Processes were in place to seek the views of people, their relatives and staff. Records showed that in addition to the resident's survey and comments box, people and staff were asked for their views on the service at meetings. The registered manager's office door was open and they completed a daily manager's walk so people had ample opportunity to speak with them. The provider also visited the service, providing people and staff with the opportunity to speak with them directly about any issues.

The service was looking outwards, they had joined the local trade association and attended the local healthcare forum. Both links provided staff with the opportunity to meet with local providers and to make links in the care industry, to strengthen their knowledge. Staff had also supported people who wished to, to participate in the local summer carnival, which pictures showed they had enjoyed and increased their community presence, with the entry winning an award. The service was no longer receiving external input from the clinical lead for quality on care homes, to enable them to improve the service, they were now more self-sufficient, but understood when to seek guidance.

The service was working in partnership with local agencies. The monthly clinic run by a nurse available to local care homes continued and incontinence training had been arranged for staff with another nurse. Staff worked in co-operation with a range of services and professionals in the provision of people's care.