The Oasis Care Home Limited

The Oasis

Inspection report

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Date of inspection visit:
03 July 2019
04 July 2019

Date of publication:
15 August 2019

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

About the service
The Oasis is a residential care home in Plymstock. The Oasis can accommodate a maximum of 35 older people in one adapted building over two floors. At the time of the inspection, 26 people were living at the service. Some people may be living with dementia. Nursing care was provided by the local community nursing teams. community nurses.

People's experience of using this service and what we found
Aspects of medicine management were not safe at the time of the inspection. The service had changed to an electronic system which had caused some difficulties. We found that a stock count of one person's medicines were not correct. Protocols were not in place for people who required additional medicines, for example for pain relief and anxiety. People's skin cream charts were not fully completed. The provider took action during the inspection period to start to improve medicine safety. Improvements included a new audit based upon best practice and increased monitoring of this area until robust, safe systems were in place.

People received person-centred care which was responsive to their specific needs and wishes. Each person had an up to date, personalised care plan, which set out how their care and support needs should be met by staff. Assessments were regularly undertaken to review people's needs and any changes in the support they required. Any needs in relation to the Equality Act 2010 were specified in care plans and if required, assessments detailed any support people required in relation to the Accessible Information Standard (AIS). The Accessible Information Standard aims to make sure that people who have a sensory loss, disability or impairment get information they can access and understand.

People had access to a wide range of group and individual activities and events they could choose to participate in, for example, music and dancing, conversation club and knitting. Special days were held for example a 1940s celebration day.

When people were nearing the end of their life, they received compassionate and supportive care. People's end of life wishes were sensitively discussed and comprehensively recorded.

Staff were aware of people's communication methods and provided them with any support they required to communicate. This helped ensure their wishes were identified and they were enabled to make informed decisions and choices about the care and support they received.

The service had appropriate arrangements in place for dealing with people's complaints if they were unhappy with any aspect of the support provided at the home. People and their relatives said they were confident any concerns they might have about the service would be appropriately dealt with by the registered manager and provider.

People were kept safe at the home and were cared for by staff that were appropriately recruited and knew

how to highlight any potential safeguarding concerns. Risks to people were clearly identified, and ongoing action taken to ensure that risks were managed well. The provider ensured that incidents and accidents were recorded and fully investigated. The home was well kept and hygienic.

Staff were well supported through training, supervision and appraisal. Staff worked effectively together to ensure people's needs were communicated and supported them to access healthcare professionals when they needed them.

People enjoyed the meals available to them, were involved in menu planning and were appropriately supported with eating and drinking where required. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The home was dementia friendly and met the needs of the people living there. A dementia "Champion" kept up to date with best practice. Staff could demonstrate how well they knew people.

People and their relatives were very positive about the care provided. People were treated with privacy and dignity and supported to be as independent as possible whilst any differences or cultural needs were known and respected.

The service had a management structure in place, and quality assurance systems were being embedded in order to drive improvements across the home. Feedback about the new leadership at the service was very good. The provider and registered manager knew people well. Regular feedback was sought from people and their relatives to ensure they were involved in the development of the service.

The last comprehensive inspection of this service was Requires Improvement (published July 2018) and there were multiple breaches of regulation. The provider completed an action plan to address our immediate concerns and we checked progress at a focused inspection in October 2018. The last rating for this service was requires improvement (published 4 December 2018). The provider completed an action plan after this inspection to show what they would do, and by when to improve.

At this inspection we found improvements had been made to how risks were assessed and mitigated, but we found concerns related to the management of medicines. Although immediate remedial action was taken to start address concerns, the provider was still in breach of regulations.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Oasis on our website at www.cqc.org.uk

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified a breach in relation to medicine management at this inspection.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of medicines management. We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Oasis

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspector, an assistant 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.

Service and service type

The Oasis 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.

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

Notice of inspection

This inspection was unannounced on the first day.

What we did before the inspection

We reviewed information we had received about the service since the previous inspection. Prior to the inspection we contacted the local authority improvement team for feedback. We reviewed previous reports and notifications the provider had sent us.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection

During the inspection we met 15 people and spoke with 10 people about their experience of the care provided. We met with seven relatives. We spoke with the providers who supported the inspection, the registered manager and six staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We reviewed staff training and the audits undertaken by the service. Maintenance and servicing of equipment was reviewed. We also reviewed the quality assurance surveys which had been undertaken.

After the inspection

Following the inspection, the provider sent us further information which we reviewed. This included the action they were taking to make improvements to medicines.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Using medicines safely
Following the previous inspection, the provider had invested in an electronic medicine system. The registered manager told us this had not been as successful as they had hoped and they were working with the electronic medicine company to address the issues.
At the time of this inspection, the provider had just returned to their previous manual medicine administration method.
•Although stock counts were in place, when we checked one person's sedative medicine and found there was not the correct amount in stock. The provider was going to investigate immediately. There was no impact on the person and additional stock was going to be ordered.
•People received their medicines safely and as prescribed however, we found not all hand-written entries had two staff signatures which helped check for accuracy.
•Some medicines needed additional controls. We found that staff had administered and signed for a medicine which had been given but failed to calculate the remaining amount of medicine correctly. The second staff checking the medicine being given had not checked carefully and identified the error. This had also not been identified by a daily audit. However, when an audit occurred this error was then identified but not reported as a medicine incident. On this occasion, the person was not harmed but failure to follow procedures can place people at harm.
•People's skin cream charts were kept in their rooms and had not always been signed by staff to indicate they had been administered. Although there were body maps to indicate where staff should apply creams to people, these had not been completed. The lack of recording meant we were unable to evidence people had their skin creams administered as prescribed to protect their skin. We found no evidence this had impacted on people's skin condition.
•PRN Protocols (as required medicine guidance) were not in place. These are instructions detailing when people may require these medicines and how people liked and needed these medicines to be given.
•No one at the service had their medicines given without their knowledge. The service understood the steps required to administer medicines without people's knowledge if needed.
•Staff were trained in medicine management and had their competency assessed. One senior care worker had overall responsibility for medicines and was aware of the action that needed to be taken to make medicines safe again.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicine safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider responded immediately during and after the inspection to undertake a medicine audit and start to address medicine safety. Staff were booked on medicines refresher training and competency checks were being repeated. Frequent daily checks were introduced following the inspection to ensure safe administration of medicines. A new audit based on best practice was also implemented during the inspection period.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made in relation to the management of risk.

•People benefitted from a service that learned lessons from mistakes to enhance safety. Accidents and incidents were recorded, reviewed and investigated where necessary by the registered manager.
•People's risks were assessed and safely managed. Assessment tools were used to help identify those at risk of skin damage or poor nutrition. The provider was now using an electronic care planning tool and staff were still learning how to use the system to its full potential.
•Risks related to people's behaviour, communication, health, continence and nutrition were documented and known by staff. Professionals, family and advocates were involved in these discussions where appropriate.
•People's behaviour was monitored where required and staff knew how to de-escalate and support people to reduce anxiety or agitation. Where required external professional support was requested promptly and additional staff provided to keep people safe.
•Staff handovers and meetings with professionals were used as forums to share information about people, discuss any changes in behaviour and consider care and treatment plans. Communication through the new computerised system meant staff were quickly aware of changes to people's health and care needs.
•Environmental checks were undertaken to maintain people's safety for example fire and equipment tests. There were improved measures to keep people safe in the event of a fire following advice from the fire service. Staff were vigilant and aware of hazards which may cause trips and falls. Evacuation plans were in place for people in the event of an emergency.
•People were kept safe as the front door was locked and visitors to the property had their identity checked and were asked to sign in.

Systems and processes to safeguard people from the risk of abuse
•Staff understood their responsibilities to protect people and their belongings. Staff had been trained on safeguarding people from abuse. Safeguarding concerns had been appropriately reported. Findings from investigations had been acted upon to improve people's safety for instance, further staff training where required.
• Key worker meetings, staff meetings, handovers and reviews with external professionals were used as an opportunity to discuss any safeguarding concerns.
• Where possible, people were supported to consider their own safety in relation to particular lifestyle choices.
• People we met and observed being cared for were comfortable with staff. They looked relaxed and there was laughter in the lounge during our SOFI.
•People told us they felt safe living at the service, "Yeah, yep. I'm well looked after." A survey during the

inspection period told us 100% of people felt safe at the service and 100% well cared for.
•Relatives were confident their family were well cared for, "No problems at all. The night staff communicate with the day staff. I've no worries or concerns" and, "[X] is safe, it is the biggest weight off our shoulders."

Staffing and recruitment
•Recruitment procedures continued to ensure the necessary checks were undertaken before new staff commenced employment. This helped ensure staff were of good character and safe to work with vulnerable people.
•People were supported by a consistent, stable staff team who knew people well.
•Visitors we spoke with confirmed the caring values of the staff team.
•There were enough staff available to support people according to their needs. We observed people were never left alone when they needed staff to keep them safe.

Preventing and controlling infection
•Good infection control practice was now in place. Staff used personal protective equipment to reduce the likelihood of infection spreading. Staff were trained in food hygiene.
•There were good housekeeping and cleaning schedules in place, the environment and people's rooms were clean and odour free.
•A relative told us, "She gets regular care and her hygiene is good."

Learning lessons when things go wrong
●Following the previous inspection, the provider had recognised there had been short fallings and additional training had been undertaken in some areas. The provider had also made further investments in the service, for example computerised care planning.
•The registered manager shared their reflections and learning from the past six months including, "Tasks were being distributed to Care Managers / carers without defining who was individually responsible for the task and what time frame to complete and report back was expected. This has now been rectified with clearer communication of expectations and identified accountability in place."
•The registered manager and provider were quick to act when things went wrong. For example, when staff did not follow safe procedures to keep people safe, action was taken to minimise the likelihood of this occurring again.

Good

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question had improved. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Assessments of people's needs were carried out before people came to live at the service. These checked people would be suited to the service and staff would be able to meet their needs. Assessments were used as the foundation of people's care plans. The content of care plans described the people we met and staff knowledge of people.
•Where possible people's family and professionals that knew them well were involved in the assessment process. Some people had stayed for a short period prior to deciding the home was right for them.

Staff support: induction, training, skills and experience
At the previous comprehensive inspection in April 2018, not all staff had received the training and supervision they required to deliver care safely. We found this area had improved.

•People were supported by staff who were skilled and understood their needs.
•Staff received face to face training from the registered manager and external providers which was regularly refreshed and updated. Topics included food hygiene, safeguarding, medicine management and infection control. Staff were encouraged and supported to undertake additional health and safety qualifications and become "Champions" in certain areas for example end of life care.
●Staff told us they had an induction when they started to work at The Oasis and opportunities to shadow more experienced members of the tea. The provider assured us essential training was undertaken prior to staff working alone.
•Staff told us they were supported by senior staff and the registered manager and we saw this reflected in the staff survey.
•One to one supervision was in place and being undertaken in addition to informal support networks.

Supporting people to eat and drink enough to maintain a balanced diet
•People were involved in creating menus around their likes and dislikes. Allergies and preferences were known and documented. New menus were implemented with the involvement of people and rotated every three months. Feedback would then be sought from people again.
•Where people were unable to express their likes and dislikes, staff spoke with their families, so they could understand what they liked to eat and drink.
•Some people were at risk of poor nutrition and these people were monitored closely with regular weight checks. The cook was aware how to support people who had special dietary requirements.
•Tables were laid attractively for lunch with cutlery, condiments and napkins available for people to use. We

observed lunch which was unhurried and saw people enjoying a curry with plenty to drink. Choices were available if people did not like the main meal. People had a menu in their bedroom and a relative told us they regularly checked the menu, which reflected what had been cooked.
•There were three main meals and snacks with cake and fruit spaced throughout the day. Taster events had been held where people could sample a variety of foods and special meals cooked throughout the year, for example on Valentine's Day or if a cultural day was being experienced at the home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•Relatives we spoke with were happy that they had involvement in their loved one's care. One relative informed us their wife didn't like being in hospital and that the home worked
with him and respected his choice to avoid any hospital admissions if possible.
•Another relative shared, "I come in at all times of the day and night and everything is always the same. Both parents receive the same standard of care and have everything they need."
•The staff team worked across organisations to ensure people received effective care. Regular reviews with health and social care professionals were arranged. If people were unwell during their stay, the local district nursing team visited.
•If people's needs changed and professional expertise was required, prompt referrals were made. For example, during the inspection one person's behaviour had changed and a referral for advice and support from the older person's mental health team was requested.
•Prompt medical advice was sought if a person had fallen or appeared to be in pain.
•The service was looking at opportunities to promote people to live healthier lives and increase people and staff well-being. Mental health training was being considered for staff and a "well-being" champion (lead) to support people and staff was in place.
•Family members we spoke with were confident when their relatives were unwell medical help was promptly sought. One relative said, "Any health issues are dealt with promptly."

Adapting service, design, decoration to meet people's needs
•The Oasis was a large home with several different areas for people to relax. In addition to the main lounge there was a television lounge and a quiet library room also used as a family room. This meant there were areas where people could spend time together, find a quiet area to read or be alone, or have space to meet with and entertain visitors.
•Handrails supported people who were mobile to move safely through the home. Walls were decorated with textured pictures for people who had sensory needs to enjoy touching. Other walls were decorated with world event pictures and world cities.
•Bedrooms were being refurbished and updated. All were in good condition. Some of the new rooms contained a kitchenette to support people to maintain their independence. Additional safety features were also in place, for example bathroom sensor lighting.
•There was signage to support people's orientation within the service and people's bedroom doors had been decorated like front doors to help them distinguish between bedrooms.
•The garden was accessible from the lounge and via a pin coded door. A safe walking trail with sensory plants for people to enjoy had been created.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

•The provider and registered manager understood their responsibilities under the MCA and appropriate applications to legally authorise restrictions had been submitted where people were unable to consent to restriction in place to keep them safe.
•Care records evidenced people's ability to consent to their care and treatment and demonstrated people had been asked for their views and consulted. For example, whether they wanted night checks, consented to photographs and whether they wished staff to administer their medicines. These decisions were kept under regular review.
•Where people were unable to make these decisions, people's family, advocates or those with the legal authority to make decisions on people's behalf had been involved and consulted. This helped ensure decisions were made in people's best interest.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported

●People were cared for and mattered to staff. People's individual differences were respected and valued in a welcoming environment. A visitor review shared, "I've visited this lovely care home several times and am inspired by the sincere welcome I get from staff and genuine warmth they show to the people that live there. It's a very special home and I only wish other care homes could be as good."

•Birthdays were celebrated with party food and a cake. The library room was used for family to celebrate this occasion with their loved one. Relatives told us staff were, "Caring, kind and all friendly."

•One staff member told us how saying small, kind things, such as "your nails look nice" helped make people feel good about themselves.

•The staff we spoke with told us they would be happy for one of their own loved ones to live in the home.

•Staff told us about an afternoon tea they arranged, and how they worked with the kitchen staff to provide a pureed version, so everybody could join in.

•Another staff member told us how they bought some foreign currency back from a trip abroad for a person living at the service, because they knew this person had a keen interest in travel and the world. They enjoyed spending time talking about the countries they had visited.

•Family we spoke with shared how pleased they were with the care their loved ones received. All told us they were made to feel welcome and one shared, "Oh yes, when I lived locally I would pop in any time. There's never any problem and I get offered a cup of tea. When my wife was unwell I was able to stay the night" and, "My wife has been here two years – loves it here, can't fault them."

Respecting Equality and Diversity

•Equality and diversity training was in progress for all staff and assessments asked people and their families if they had any support needs in relation to sexual or gender identity, faith or culture. Staff understood and respected people's needs regardless of their disabilities, race, sexual orientation or gender.

•During our observations of care, interactions between people and staff were patient and kind. Staff explained to people what was happening if they were moving them and provided reassurance to people who appeared unsettled.

•Staff were aware of people whose mood seemed low and those who were isolating themselves. Staff considered ways to help improve their self-esteem and sense of value.

•Some people had built friendships at the home and these were valued by people and encouraged by staff.

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

●Where possible people were actively involved in their care decisions.

•We saw from care plans where people had contributed their preferences in how they liked and wanted their care delivered.

Respecting and promoting people's privacy, dignity and independence

●People we spoke with told us how their independence was encouraged. For example, by being supported and encouraged to undertake and be involved in aspects of their care they were able to stay mobile and maintain their interests.

•People who liked their privacy and own space were respected by staff. Some people preferred to stay in their rooms and staff accepted this but also checked frequently that people were content.

•People's dignity was maintained. We saw staff knocking before entering people's rooms. We observed people were dressed as they liked and had their important belongings with them, for example, ladies had their handbag.

•Some bedrooms had kitchenettes where people could make family and visitors a drink and store their own food items. This helped people maintain their independence.

•We saw during our observations where people were encouraged to walk. One staff gently guided the person by their side whilst another was behind them with their wheelchair in case they tired.

•Staff we spoke with talked with a sense of pride in their work. They were committed to giving people the best care they were able to.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•The assessment process was thorough to support people's transition to The Oasis. People were assessed prior to their move to the service. The assessment checked people's needs could be met by the service and their preferences for care were known.
•Care plans were detailed and contained information which was specific to people's individual needs, the routines they liked and those important to them. Since the previous inspection the service had invested in electronic care records. This enabled staff to record more detailed information about people's needs, as well as promptly access information about changes or risks.
•People's preferences were understood and respected. For example, people's night time routine, whether they liked their windows open or closed at night, preferred time to retire, how many pillows they preferred, and whether they wished to be checked by staff.
•People's social needs were known and encouraged, for example one person had her church friends visit in her room, another person had internet in their room, so they could video call family abroad and use the internet which they enjoyed.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
•There was information in place to enable the provider to meet the requirements of the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they are given. For example, if people needed information in a larger font this was possible.
•People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others as required. We met one person who had a pictorial communication book to help them make their needs and preferences known.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
•People enjoyed activities to their personal taste and individual needs. Activity staff supported people to remain stimulated.
•During the inspection, people were seen singing and dancing to songs from their past. A special 1940's day had been arranged and staff and people had enjoyed dressing up. We met people who enjoyed reading, knitting and one person who was happy encouraging the birds to visit by the window of their room. Other

people enjoyed outings with their family.
•Another person told us about "conversation club" which was enjoyed. One person at the home researched the topic, finding information and pictures to stimulate discussion.
•Activities staff had created a "rummage basket" and sourced games for people to do outside of their working hours. A selection of activities for care staff during the evening were also used to encourage people to participate in the service, for example folding laundry. This supported people to feel helpful and valued.

Improving care quality in response to complaints or concerns
•There were systems and procedures in place to manage complaints. This was visible to people who used the service. A relative told us, "Yes, I have no worries or concerns. Under the current circumstances she has everything she needs."
•The registered manager told us about two complaints they had dealt with. . Both had been resolved to people and relative's satisfaction.
•People who were able to verbally share their views told us they would speak to staff if they had a complaint.

End of life care and support
•The service worked with people, their families and professionals to develop end of life care planning ensuring care would be dignified and pain free during people's last days and weeks.
•Relatives told us they had met with staff to discuss this area and they had found this reassuring.
•Some senior staff had received training in end of life care and there was a dedicated "End of Life" Champion. Champions are staff with leads in a particular area.
•Where appropriate, people had written plans in place regarding resuscitation.
•Feedback we reviewed was positive about the care and compassion shown to people at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remains the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection a recommendation had been made to improve care planning audits. We found this area had improved. However, the monitoring of medicine safety had not been robust.
•New governance systems were still being embedded. In addition to daily and monthly checks, a new quarterly audit monitored areas of compliance. Actions resulting from these checks were monitored by the registered manager.
•These internal audits and incidents had identified the problems with the electronic medicine system. However, the system in place to manage the change (electronic medicines administration to manual medicine administration) had not ensured systems were safe creating potential risk to people.
•The registered manager started to take action during the inspection period developing a new medicine audit based on best practice guidance.
•The provider and registered manager were well known at the service by people, their families and staff. We were told by people and staff the leadership team were hands on and we saw from a recent staff survey staff had confidence in their ability to lead the service.
•The registered manager was new in post and the management structure was developing with roles and expectations being clarified. The registered manager told us there was now clarity regarding the roles of the care managers supporting him and better delegation.
•Family feedback included, "Got a lot of respect for him [the registered manager] – you can see so much has changed – more emphasis on caring. It's hard to explain, staff buzzing around a bit more."
•The leadership team were committed to offering a good service to people and used regular audits across the service to identify areas for improvement. These included health and safety audits, care planning audits, reviews of incidents and accidents and reviewing people and staff feedback through the quality assurance questionnaires.
•Resident and family meetings were held frequently to gather views and opinions of the service and keep people up to date.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
•We found the leadership team to be honest and open. They were aware of the areas that required improvement and open to suggestions and feedback.
•People and family told us management were approachable, listened and when things went wrong,

apologised and made improvements. One commented, "Yes, it's very different with the manager now. You can talk to them. I can have a meeting with them if I want. [X – a care manager] is marvellous."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The provider and registered manager understood their roles and responsibility to maintain compliance.
•Notifications had been submitted in a timely way. The provider information return had been submitted on time and an additional evidence folder for inspections had been created.
•The registered manager was still learning what they were capable of doing and the areas where additional support was required. For example, they had been undertaking all the staff essential training. Following reflection and a greater appreciation for all of their responsibilities, they recognised moving forward they needed help to enable staff to receive the appropriate level of training required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People were listened to. Daily walkarounds enabled conversations with people. People were also asked their opinion through frequent surveys.
•Staff were involved and respected for their contribution. Staff meetings and one to one meetings enabled staff to feedback and raise suggestions. A staff survey provided further opportunity to be involved in developing the service.
•One staff member told us they had been given a "Champion" role. They said this had made them feel valued and gave them greater insight to be able to support people. Champion roles meant staff had skills, training and knowledge in certain areas and would be a resource to staff and people in that particular area.

Continuous learning and improving care
●The management team had learned from previous inspections and had taken action to make things better. Prompt action was taken during the inspection period to medicine safety.
•Continuous feedback and reflection enabled progress. For example, the registered manager told us, "I initially insisted that every resident had their food and fluid intake recorded onto CareDocs (electronic recording system). This has proved both time consuming and unnecessary. We now only monitor and assess those residents at risk."
•The registered manager was due to undertake a health and social care leadership course in 2020.

Working in partnership with others
●There was a plan in place to improve partnership working and be more active participants in the local forums where best practice was discussed. The registered manager shared, "Care managers will now share attending the local authority (QAIT), CQC, safeguarding, wraparound events etc along with other functions." The impact of this has yet to be established.
•There were relationships with the local primary school and children had visited as part of the Christmas festivities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not always safe.