Clare Hall
Provider: Cherry Garden Properties Ltd

MOCK INSPECTION REPORT

Date of Audit: *25th April 2024*
Duration of Audit: *1 day on-site*
Date of report: *3rd May 2024*

OUTSTANDING OVER 87%	GOOD 63% - 87%	REQUIRES IMPROVEMENT 39% - 62%	INADEQUATE 25 – 38%

Care 4 Quality Rating Opinion			
	Score	%	RATING
SAFE	24	75	Good
EFFECTIVE	18	75	Good
CARING	15	75	Good
RESPONSIVE	21	75	Good
WELL-LED	21	75	Good
SERVICE RATING	Good		

Consultant: *Shirley Kirkcaldy*
Feedback Sheets: *x 2 [emailed]*

This opinion is based on the evidence gathered during the audit visit and further evaluation in relation to where the service would sit in terms of compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The New Framework scoring and rating judgement by the CQC will be based around continual evidence gathering over time. <u>However, we are only able to provide a judgement based on the evidence provided on the day/days of the visits</u>. Our findings will be scored in line with CQC rating methodology, including applicable evidence categories

Compliance Judgements

The judgements are made against the:

- Internal Quality Outcomes, Policies & Procedures
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Judgements and recommendations related to H&S Legislation are made with reference to the following:
    - Management of Health and Safety at Work Regulations 1999
    - Workplace (Health, Safety and Welfare) Regulations 1992
    - Health and Safety at Work Act 1974

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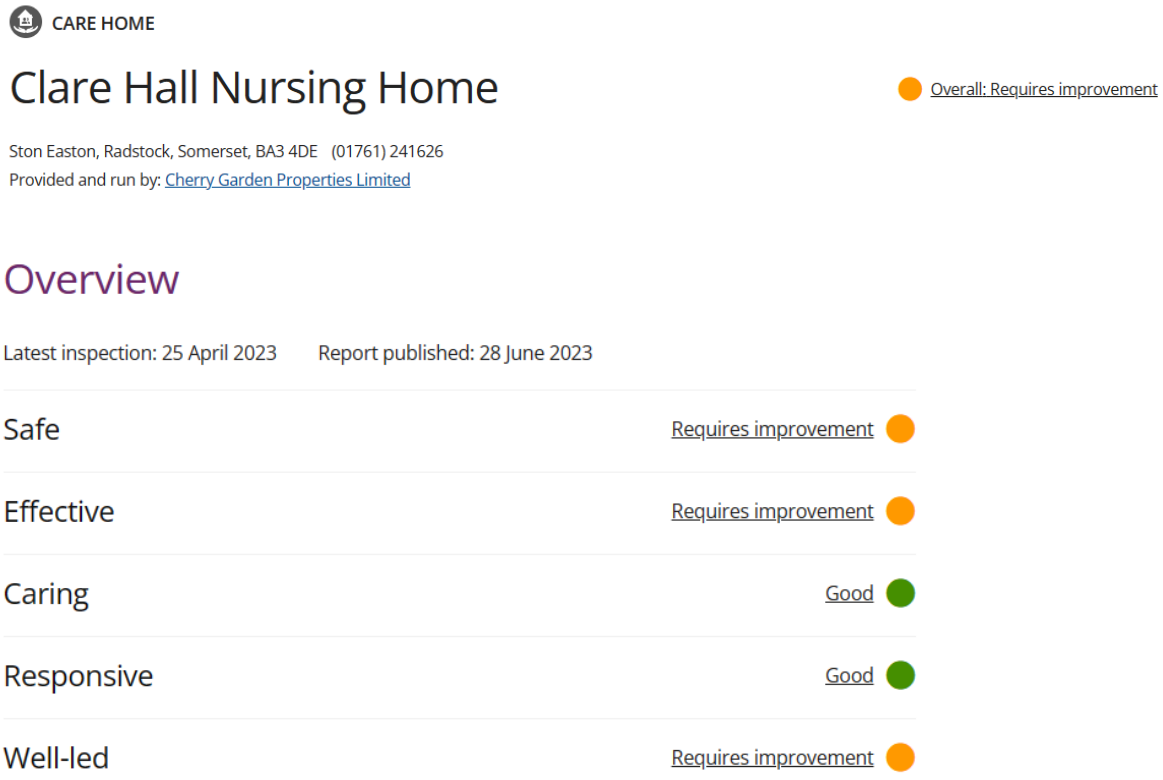
Our view of the service

The service last had a full inspection by CQC on the 25th of April 2023 and achieved the following rating: Requires Improvement


CARE HOME

Clare Hall Nursing Home

Overall: Requires improvement

Ston Easton, Radstock, Somerset, BA3 4DE (01761) 241626
Provided and run by: Cherry Garden Properties Limited

Overview

Latest inspection: 25 April 2023 Report published: 28 June 2023

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Clare Hall is a nursing home registered to provide care and accommodation for up to 51 people, some of whom are living with dementia or require the support of registered nursing staff. The current occupancy was 38.

A Registered manager was in post, appointed four months ago, and supported by a Deputy manager and a Compliance manager. The service had been under the Local Authority Quality Team for several months but all actions had now been completed. The most recent CQC inspection rated the service as Requires Improvement in Safe, Effective and Well Led.

Summary of the Visit

This was an announced visit, the purpose of which was to undertake a home audit under the Single Assessment Framework and to review progress made against the action plan drawn up by C4Q in response to their September 2023 visit and CQC findings in April 2023.

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The Registered Manager, Deputy Manager and Compliance Manager were present throughout the visit. The methodology used to help understand the experiences of people who used the service included a review of the action plan and key documentation, discussions with the registered manager, deputy manager, compliance manager, registered nursing staff, care staff, chef, activity coordinators, three residents and one family member. Observations of staff/resident interactions were also undertaken.

Audit Findings

SAFE – People are protected from abuse and avoidable harm			**Good**	
The total possible score for SAFE is: 32			**SCORE**	**%**
			24	**75**
4 = Evidence shows an exceptional standard	**3 = Evidence shows a good standard**	**2 = Evidence shows some shortfalls**	**1 = Evidence shows significant shortfalls**	
Learning culture	*Regulations 12,16,17, and 20*		**Score (1 -4):**	**3**
We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.				
The culture of the home was open, transparent and positive, with staff who were aware of people's individual safety and support needs. The staff team was diverse and multicultural. They were seen to work well together and language barriers were not apparent during the visit. The manager was compliant with the Duty of Candour and notifications had been reported to CQC, Safeguarding, the Local Authority, and other relevant stakeholders. It was noted that one notification involving a grade 3 pressure ulcer had been made to Safeguarding on 8.4.24 but not to CQC. **Action Required** Incidents and accidents were reported on the online system which the deputy manager reviewed regularly and documented each one with details of action taken or signed off if no action was required. This evidenced a robust approach to continuous improvement. Handover sessions were verbal and aimed to ensure the effective transfer of information from one shift to the next. It might be of benefit if these were to be documented and also evidence of staff allocation. **Action Recommended** Discussion forums for staff included regular supervisions, team meetings and shift handovers.				
Safe systems, pathways and transitions	*Regulations 12 and 17 (9)*		**Score (1 -4):**	**3**
We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.				
Procedures for the transfer of information between services were in place in the form of online Hospital Passports and these were completed well. This promoted the continuity of safe care for people having to move outside the home, either permanently or temporarily e.g. a hospital admission. People's personal information was treated in line with the Data Protection Act and GDPR.				

Collaborative working with external agencies, authorities and health professionals was evidenced and systems were in place to ensure that the staff team proactively managed any potential concerns through timely referrals. For example, involvement of GP, SaLT, Physio, Dentist, Chiropody and Optician services was evident.

Behaviour concerns were identified, and strategies were found with the support of relevant services. Staff had received Challenging Behaviour and Dementia Awareness training but one of the registered staff members commented that more training in these areas was required. This was discussed with the manager who said that plans for more advanced dementia training was being looked at.

Safeguarding	*Regulations 11,12,13, and 9 (17,20)*	**Score (1 -4):**	**3**

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

People's human rights were promoted within an open and inclusive culture and upheld through an up-to-date safeguarding policy and procedure.

People were protected from abuse by staff who had completed safeguarding training and knew how to report concerns and what action to take to protect people.

Information for people about how to report a safeguarding concern externally was displayed and the manager was proactive in ensuring transparency with all relevant authorities including CQC and Safeguarding.

Safeguarding alerts were well managed and documentation evidenced regular monitoring. Audit outcomes were used to mitigate reoccurrence. There was one possible open incident which the safeguarding team had discussed verbally with the home and the manager was awaiting confirmation of closure.

People whose liberty was restricted were assessed and a DoLS application was made to the local authority. Recording and monitoring procedures were effective and people's rights were protected.

People spoken to were aware of how to make a complaint or raise a concern and there were no open complaints at the time of the visit.

The Duty of Candour was well evidenced.

I Statement:
One person said, *'I always feel safe and well looked after, staff are kind and lovely. I would tell them if I had a problem or talk to J or K [Manager or Deputy].*

Involving People to Manage Risk	*Regulations 9,11, and 12 (10)*	**Score (1 -4):**	**3**

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Personalised, individual risk assessments were completed online at Log My Care and included Waterlow, MUST, moving & handling, skin integrity, choking, catheter care and others. People who experienced incontinence had their needs met in a person-centred manner. Continence assessments were in place, referrals were made to external professionals and continence aids were detailed in care plans.

Some continence products were stored on the floor.

Action Required

Care plans provided guidance for staff in managing people's risk factors. Involvement of the resident or their family representative in care planning and reviewing was apparent and all were written in 1st person.

Restrictive practice such as the use of a sensor mat was either consented to or assessed through an MCA with a Best Interest Decision and involvement of relevant people such as family or LPOA. If a person exhibited behavioural challenges, advice and support had been sought through appropriate external referral.

Information about resuscitation wishes was documented i.e. TEP as well as contact details of family, GP and relevant healthcare professionals. Named nurses and nursing assistants were documented.

Where a high fall risk was identified, a care plan was completed. Oral care needs were assessed and relevant care plans and training were in place. People's weights were recorded according to need.

PEEPs were in place on Log My Care as well as a summary and individual records in a fire file located in reception in case of a fire emergency. H&S and fire risks were safely managed and reviewed. *Ref: Safe Environment*

Safe Environment	*Regulations 12, 15 and 17*	**Score (1 -4):**	**3**

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

SEEN	EVIDENCE	COMMENTS/ACTION
☒	H&S Risk Assessment	
☒	Business Continuity Plan	
☒	External Fire Checks	
☒	Gas Safety Certification	11/2023
☒	5-year Electrical Safety	12/2021
☒	Deep Cleaning System	
☒	PAT Testing	04/2024
☒	LOLER	
☒	Legionella Testing	
☒	Food Hygiene Rating	5*
☒	Window Restrictors	
☒	Lighting Checks	
☒	Water Temperature Checks	Baths & Showers weekly, basins monthly
☒	Mattress and pump Checks	
☒	Wheelchair Checks	
☒	Call Bell Checks	Call bell records are printed daily and reviewed.
☒	Sensor Mat Checks	
☒	Furniture Checks	Part of the daily walk around
☒	Fire Extinguisher Checks	
☒	Fire Alarm Testing	Weekly
☒	Fire Drill (6 monthly) Day	
☒	Fire Drill (6 monthly) Night	

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☒	Emergency Lighting Tests	Monthly
☒	Fire Door Checks	15 per week are checked
☒	Emergency Grab Bag	

SUMMARY

Environmental risk assessments had been completed and relevant policies were in place. A comprehensive maintenance and H&S programme was evident and two maintenance persons were employed.

The environment was clean, comfortable and welcoming. Practical flooring had been laid in corridors, adaptive equipment had been considered and fittings and furnishings were in good condition. The home was free of malodour.

Internal safety checks had been completed including fire doors, fire extinguishers and emergency lights.

Electromagnetic door closures were checked routinely. Fire exits were clear and communal corridors were uncluttered.

Compliant window restrictors were fitted and checked monthly. Window safety checks were also completed and the extractor fan underwent monthly cleaning.

Daily visual checks of the environment were completed by the manager or deputy manager during their walk around the home which included two bedrooms and lounge/dining areas.

The use of equipment such as profiling beds, bed rails, hoists and wheelchairs was risk-assessed and checked regularly.

Adapted bath and toileting aids were in place and where people required a hoist transfer, slings were for individual use.

LOLER inspections were up to date.

Fire safety had been addressed and a risk assessment was completed on 14.07.2023. Fire training was up to date and four Fire Marshalls had been trained. Fire drills were held six monthly with the last one being 05.03.2024 when eighteen staff attended.

The Fire Safety Log required a new front page for 2024 recordings.

Action Required

An Asbestos survey had been completed.

A Legionella risk assessment was in place. Water safety checks, weekly flushing records and quarterly shower head cleaning and disinfection were evidenced. TMVs were fitted to hot water outlets and water temperature checks were being completed.

An alert board in the clinical office identified alert mats and safety equipment in use and a maintenance book was in place for staff to record items needing repair or attention. Bed rail checks were completed weekly.

Consideration had been given to orientation aids for people with dementia such as signage and named doors.

Infection prevention and control precautions were effective and well managed, PPE and hand gel stations were located throughout the home and bathroom and toilet areas were well equipped and maintained. Handwashing signage was

displayed. Cleaning records for different zones of the home were completed daily or weekly. Deep cleaning was evidenced.

A Business Continuity Plan was in place but would benefit from the addition of Climate Conditions/Adverse Weather.

Action Recommended

Staff accommodation on the top floor was not visually inspected during the visit.

Safe and Effective Staffing	*Regulations 12, 18 and 19*	**Score (1 -4):**	**3**

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

Three staff files were checked to ensure safe and effective recruitment in line with Schedule 3 of the Health & Social Care Act. These were compliant and included an application form with no employment gaps, verified identification documents, a job description, an offer letter, and an employment contract. DBS issue date and certificate number were documented.

Staff confirmed they had completed an induction programme, which introduced them to the home's policies and procedures, care and other records to support their understanding of people's needs.

Training was provided via an online platform [Grey Matter Learning] as well as in-house and completed with a high compliance rate. Matrix were available for both and requirements were monitored and planned to support each staff member's continued learning. This included NVQ level 3 and beyond and new staff were required to complete the Care Certificate as part of their induction. Four Fire Marshalls had been trained. Learning disability and Autism training had been completed [Oliver McGowan].

Clinical staff had access to nurse-related training such as PEG, catheter care, dysphagia, verification of death, syringe driver management and other topics. Medication training and competency assessments were also completed.

In a discussion with one of the clinical staff GW [RMN], they felt that more training was needed for challenging behaviour and Dementia as well as Tissue viability for registered staff. This was passed on to the manager and deputy during feedback, who confirmed that more advanced dementia training had already been sourced and other requirements would be looked at.

Action Recommended

There was an effective competency framework in place which evidenced a range of skills including, for example, medication, infection control and handwashing.

The home used a dependency tool to determine staffing needs and currently was over-staffed by 34%. The team included nursing and care staff, activity coordinators, a housekeeping team, two chefs, administrators and two maintenance persons. Waking staff covered night duties. People using the service agreed there were sufficient staff to help keep them safe.

I Statements: One person said, '*Staff are always here to help me'.* Another said, *'I don't normally have to wait long before they answer my bell, the staff are lovely'.* This was evident during the visit e.g. VH who rang for assistance whilst I was chatting to them.

All staff spoken to said they felt they had enough staff to do their job and enjoyed working at Clare Hall.

Infection, Prevention, and Control	*Regulations 12, 15 and 17*	**Score (1 -4):**	**3**

We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

Infection prevention and control was well managed and safety systems were in place to protect people from the risk of infection. Monthly audits relating to Infection Prevention and Control [IPC] were completed and used as part of the governance framework to mitigate potential IPC-related risks. It was recommended that bed bumper checks be included in the audit [new ones had recently been ordered].

Action Recommended

Some incontinence products were being stored on the floor [Ref: Infection Control].

Deep cleaning was completed monthly across both floors of the home.

PPE was available in key locations and staff used it appropriately. Covid-19 precautions were in place including a signing-in system for staff and visitors. Handwashing signage and posters were on display and Outbreak Management procedures were in place.

A housekeeping team maintained a very clean and odour-free environment, managed by a head housekeeper. Tray tables were wiped down regularly throughout the day, upholstery and seating were clean and the flooring was intact.

Where bed rails were used, they were clean and free from damage, thereby preventing ingress of dirt.

Paper towels and soap dispensers were wall-mounted in bathrooms and toilets.

Waste bins seen were lidded and foot operated and clinical waste was safely managed. Red laundry bags were in use for soiled linen and colour-coded mops complied with national guidelines for the prevention of the spread of infection.

The laundry was clean and safely managed, with clean and dirty items being separated in containers e.g. red linen bag for soiled and dirty laundry. Lint was removed from drying machines when alerted.

The home's EHO rating was 5 stars. The kitchen was well organised and records evidenced cleaning schedules and temperature checks. Food storage was safe, with labels on covered items of food, indicating when it was to be disposed of. Two bins were in place, both lidded and foot-operated. Food hygiene training had been completed.

Medicines Optimisation	*Regulations 9, 12 and 11*	**Score (1 -4):**	**3**

We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

People living at the service had their medication support needs assessed and documented on Log My Care and received prescribed medication safely from staff who had completed relevant training and had their competency checked. Nursing staff were responsible for administering medication and were observed wearing a red alert tabard to avoid interruptions.

People's consent was recorded or an MCA and Best Interest process followed.

Residents' preferred way of accepting their medication was identified and medication allergies were noted in care plans and on MAR charts along with DoB, photo ID and GP details. MAR charts were completed well, without signature

gaps and double-signed where necessary. Correct coding was evidenced on the back of MAR where relevant. A staff signature list was maintained and current.

Topical medicines were recorded on TMAR charts and body maps were used for trans-dermal patch recording with sites of application marked clearly. When checked with the RGN on duty it was found that numerous creams located in people's ensuites had not been dated when opened.

Action Required

PRN protocols were in place and a review date was identified. These included records for GTN and Lorazepam. Medication packaging had original pharmacy labels in place.

BNF could be accessed online via the relevant App.

Medication in use was stored in secured trolleys. Additional medication was located in locked cupboards in the medication room. Medication fridge and room temperatures were monitored and documented. Stock levels were appropriate.

Anticoagulant and Emollient risk assessments were in place, the latter also having a body map.

A compliant CD cupboard contained people's controlled medicines. A CD register was in place and double signatures were evidenced. CDs had regular stock checks applied.

Sharp's containers were located in the medication room and labelled appropriately. The temporary closure should be shut unless in use.

Action Required

Homely remedies were safely managed and had GP approval.

Keys were held by the person in charge. Returns to the pharmacy were safely managed and documented.

A policy was in place and monthly medication audits were completed.

Actions Identified:

- Grade 3 [and above] pressure ulcers require CQC Notification.
- Ensure that continence products are properly stored.
- Fire Safety Log – new front sheet for 2024 needed.
- Creams to be dated when opened.
- Temporary closure on Sharp's containers to be closed when not in use.

Actions Recommended:

- Consider written handovers.
- Business Continuity Plan to include Climate Conditions/Adverse Weather.
- Consider more advanced dementia training, challenging behaviour, and tissue viability for clinical staff.
- Include bed bumper checks in IPC audits.

EFFECTIVE – People's care, treatment and support achieve good outcomes, promote a good quality of life, and are based on the best available evidence				**Good**	
The total possible score for EFFECTIVE is: 24				**SCORE**	**%**
				18	**75**
4 = Evidence shows an exceptional standard	**3 = Evidence shows a good standard**	**2 = Evidence shows some shortfalls**	**1 = Evidence shows significant shortfalls**		
Assessing needs	*Regulations 9 and 12 (10, 11,17)*			**Score (1 -4):**	**3**

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

Risk assessments and care plans were developed from pre-assessment information, through observation from the point of admission and with the involvement of a resident or their family representative. This was evidenced in care plans and Best Interest processes followed where appropriate.

Care plans were person-centred, detailed, and provided effective guidance for staff when supporting people. They were reviewed monthly or as a person's condition changed. Specialist plans were in place for conditions such as Diabetes and Seizure Disorder and included detailed signs & symptoms as well as escalation plans in the event of an emergency. PEG and catheter care plans were sufficiently detailed and provided directions to staff for safe management and IPC considerations.

Personalised care and treatment were provided, and people's choices, preferences and abilities were considered, including communication needs in line with the AIS. This ensured that effective outcomes were optimised.

D2A assessments were in place for those people admitted under this system. According to the manager and deputy, very few discharges took place in the six-week window and most lasted considerably longer.

People's behaviour and emotional support needs were assessed, and plans were put in place to support these as necessary. Where professional input, assessment or advice was required, referrals were made to relevant health agencies.

Weight monitoring was based on assessed needs and risk factors. Where people needed their health and well-being monitored, recording tools such as fluid, food and repositioning charts were in place and recorded on Log My Care.

End-of-life care plans were documented. Staff had completed end-of-life training.

Six care plans were reviewed on Log My Care [VJ; CS; MB; JH; FA; RL], with one issue noted: JH – continence care plan did not mention the use of intermittent catheter due to moisture lesion and there is no relevant risk assessment.

Action Required

Delivering evidence-based care and treatment	*Regulations 9, 10, 12, 14, and 17 (11)*	**Score (1 -4):**	**3**

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

Care plans were person-centred, holistic and evidenced involvement of either a resident or their family member. The service was proactive in referring people to health professionals for support as required support. Emergency situations were managed safely.

Best practice guidance and standards had been followed, for example, NICE guidelines[medication], SaLT assessments and H&S [use of equipment and inspection checks]. Communication care plans evidenced AIS considerations and individual communication abilities, support and means of expression were recorded. People were supported to maintain meaningful relationships, both inside and outside the home, and to pursue their individual areas of interest.

Where a person was at risk of poor nutrition or dehydration, care plans reflected assessed risks and staff were aware of these individuals. Specialist healthcare professionals were involved in people's nutritional care if needed, for example, if someone was at risk of choking and/or aspiration. Food charts were documented where required. Where a risk was identified optimal fluid targets were set and intake was promoted, monitored and recorded. Jugs of juice were located in bedrooms and changed regularly.

People who had a condition such as Diabetes or Seizure Disorder a plan was in place to support them. Wound care plans were in place. Dysphagia training and choking care plans were completed.

Best practice guidance was followed by the catering and housekeeping team in line with Food Safety and Infection Control guidelines. The chef spoken to clearly understood individual dietary requirements and all aspects of food hygiene.

How staff, teams and services work together	*Regulations 9 and 12 (17)*	**Score (1 -4):**	**3**

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Staff worked effectively as a team and were well supervised and supported. Communication between the various teams i.e. care, housekeeping, catering and maintenance was evident and a handover for care and nursing staff was completed. A written handover is recommended [Ref: Learning Culture].

The service had established positive relationships with external professionals and agencies. A regular GP round took place as well as emergency visits when required. Appropriate referrals were made to SaLT, OT, Dietician etc.

If a person transferred out of the service, information accompanied them by way of a Hospital Passport, which was detailed and holistic. Information was received in advance of a new admission or a person transferring into the home.

Supporting people to live healthier lives	*Regulations 9 and 12 (10, 11)*	**Score (1 -4):**	**3**

We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

People had access to healthcare services and a regular GP visit reviewed care needs including medication. People were encouraged to attend appointments with their optician, dentist and chiropodist and supported to live a healthy life whilst also maintaining and respecting their individual choices and preferences.

Referrals to specialist practitioners were made when required, to promote the best outcomes for people. Staff were able to support other professionals with tasks such as monitoring baseline recordings, weights, venepuncture, and blood sugar monitoring as examples.

RESTORE 2 had been implemented which monitored a person's physical deterioration and escalated it appropriately/ Activity provision included the promotion of physical movement and coordination.

Monitoring and improving outcomes	*Regulations 12 and 17 (9)*	**Score (1 -4):**	**3**

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent and that they meet both clinical expectations and the expectations of people themselves.

Care plans were reviewed with the involvement of the person or their family representative at least monthly as a person's condition changed.

A daily walkabout by the manager or deputy allowed for monitoring of people's needs and conditions and for prompt action to be taken if necessary.

People's outcomes were optimised through effective risk assessment and care planning, from pre-assessment to end-of-life.

Consent to care and treatment	*Regulation 11 (9, 10)*	**Score (1 -4):**	**3**

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

People were encouraged to sign their own consent records if able, for decisions such as medication administration, accommodation and care, use of photos and sharing of information.

Mental Capacity assessments were completed with Best Interest Decisions, in consultation with relevant people such as LPOA, family, GP etc.

A DoLS tracker was used for submitted applications where a person's liberty was restricted. There were no required DoLS conditions at this time.

Staff had completed MCA training. Verbal consent was sought prior to any support provided.

Where copies of LPOA were held it was agreed that they would be stamped to verify that the original had been seen. Alternatively, validation can be sought through the Office of Public Guardian using the OPG100 form or by contacting them by telephone.

Action Recommended

Actions Identified:

- Amend JH's Continence care plan.

Actions Recommended:

- Validate copies of LPOAs.

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CARING – The service involves and treats people with compassion, kindness, dignity, and respect.				Good	
The total possible score for CARING is: 20				SCORE	%
				15	75
4 = Evidence shows an exceptional standard	3 = Evidence shows a good standard	2 = Evidence shows some shortfalls	1 = Evidence shows significant shortfalls		
Kindness, compassion and dignity	*Regulations 9 and 10 (12)*			**Score (1 -4):**	**3**

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

The service had established partnerships with numerous external health professionals and agencies and worked in close collaboration with them.

People spoken to were overall positive about the quality of care and support they received, this included one person who had been transferred from the hospital recently and previously lived at another home. They said that they had settled in well and liked living at the home and that *'staff were kind and respectful'.* People also said that they felt supported to make choices in their daily lives and had been asked about their preferences for food and activities.

Observations confirmed that staff understood individual needs and abilities and spoke to people with kindness and compassion.

Staff maintained people's privacy and dignity in particular when assisting people with personal care, for example, by knocking on bedroom doors before entering, gaining consent before providing care, and ensuring curtains and doors were closed. Communal bathroom doors were locked when in use to protect people's privacy.

Wellbeing was promoted through person-centred care plans which included emotional, physical, psychological and social support needs.

Staff survey findings were positive as was staff feedback during the visit. Staff appeared happy, engaged and supportive of each other.

I Statement: One person living at the service said, *'I wouldn't want to be anywhere else, the staff are so kind and thoughtful here'.*

I Statement: One staff member said, *'I like working here, staff support each other, the manager and deputy are always available if I need to ask them anything and it's a good place to work'.*

Treating people as individuals	*Regulations 9, 10, 14 and 15*	**Score (1 -4):**	**3**

We treat people as individuals and make sure their care, support and treatment meet their needs and preferences. We take account of their strengths, abilities, aspirations, culture, and unique backgrounds and protected characteristics.

People's life history was identified, and a document called 'The Story of a Lifetime' was completed where possible for each person by the activity team.

Communication care plans identified the level of support needed and mental capacity was assessed to determine decision-making ability and identify any support required.

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People's bedrooms were personalised and those spoken to were very happy and settled and supported to follow their personal interests and hobbies through the extensive activity programme on offer.

A lunchtime observation showed that people had a choice of where to take their meal. The dining room was large and tables laid attractively. The environment over lunch was quiet and relaxed, and people were observed interacting with each other. Staff were on hand and supported people to eat with discrete prompting and assistance if, needed.

Pictorial menus were available to support people in making meal choices. Mealtimes were audited to promote continuous improvement in this aspect of the service.

Independence, choice and control	*Regulations 9 and 12 (10)*	**Score (1 -4):**	**3**

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

People's independence was promoted through personalised care plans which supported individual abilities, preferences and choices, risk assessments, best interest decision-making and the facilities within the service.

Staff understood person-centred care and were able to explain how people were given choices in their daily lives and this was evident during the visit.

Equipment to support mobility and safe transfer was in place. Where required, hoist slings were for single use only. Adaptive equipment was provided for people who required support with mobility and eating and drinking, for example.

Signage around the home helped with orientation and people were seen making their way independently to the lounge, dining room and toilet areas. Bedroom doors displayed people's names which helped with recognition.

People were supported to maintain meaningful relationships, inside and outside the home. Friends and family were welcomed and relevant next of kin were involved in the review of their relative's care and support needs. Choices and preferences included in care plans were regularly reviewed and updated as people's needs changed.

A comprehensive activity programme was based on people's hobbies and life history information. The activity team worked across seven days, with three days being covered until 8pm which allowed for additional support to people with dementia or sundowning needs. Examples of people's activities and artwork were on display and activity provisions were plentiful. Musical entertainment was taking place on the day of the visit and this was very well attended and enjoyed, with people singing along and staff interacting and dancing. Activity folders evidenced an extensive display of activities that ranged from baking to craft to gardening to outings and more and the two coordinators spoken to were enthusiastic about their roles.

Individual choices had been considered; one person had a TV programmed into the particular programmes they enjoyed and signage was in place for staff. Another gentleman had a piano in his bedroom with sheet music collected over the years and it was very apparent this meant a lot to him.

I Statement: *One person spoken to said, 'There is always something going on, I love to do the quizzes and the music and they have pets come in to see us. The manager's dog is lovely'.*

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Responding to people's immediate needs	*Regulations 9, 10, 11 and 12 (16)*	**Score (1 -4):**	**3**

We listen to and understand people's needs, views and wishes. We respond to these at that moment and will act to minimise any discomfort, concern or distress.

Effective systems were in place and care plans were sufficiently detailed for staff to anticipate needs and respond promptly. This included emergency situations that required timely intervention.

People's views and wishes were considered in the daily life of the home and this was evident in documentation and the way staff responded to individual needs.

People's communication abilities had been assessed in line with the AIS.

Workforce well-being and enablement	*Regulations 9, 12, 17, and 18*	**Score (1 -4):**	**3**

We care about and promote the well-being of our staff, and we support and enable them to always deliver person-centred care.

Staff were supported by a comprehensive training programme and opportunities for advancement through NVQ qualifications and specialist training. The Care Certificate provided new staff with a thorough induction and promoted the delivery of person-centred care. Staff feedback was positive about access to training and being kept informed of people's needs through regular handover sessions and feedback.

Supervisions offered opportunities for staff to discuss any issues or concerns and these were all up to date. Fourteen annual appraisals have also been completed to date this year.

Staff levels were good with 34% overstaffing at present.

Mental health first Aiders had been trained and information was displayed with relevant contact names.

Staff meetings were held and clinical staff also had regular meetings. Clinical governance was provided by the registered manager and validation records were maintained.

The manager and deputy manager operated an open-door policy and were supportive of staff and flexible to their needs. An on-call system was in place across seven days.

Volunteers were not used in the service.

Actions Identified:
N/A

Actions Recommended:
N/A

RESPONSIVE – The service meets peoples' needs				Good	
The total possible score for RESPONSIVE is: 28				SCORE	%
				21	75
4 = Evidence shows an exceptional standard	3 = Evidence shows a good standard	2 = Evidence shows some shortfalls	1 = Evidence shows significant shortfalls		
Person-centred care	*Regulations 9 (10, 11, 12, 14)*			**Score (1 -4):**	**3**

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

People were at the forefront of care planning and included, where possible, in the process. Their needs, choices and preferences were considered and supported by staff who understood and knew them. Several examples of kindness and consideration were observed during the visit.

Individual assessed needs covered all ADLs, specialist conditions and behaviour support. Care plan reviews were completed on average monthly, more often if the need arose or a condition changed.

End-of-Life plans were in place but most lacked details of personal preferences. It is understood that this information was not always available and, in these instances, the care plan did state this.

Care provision, integration, and continuity	*Regulations 9, 12 and 17 (10)*	**Score (1 -4):**	**3**

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Continuity of care, support and treatment was provided through appropriate pre-assessment and with the input of specialist practitioners and health professionals to promote continuity and joined-up care. There was documented evidence of GP district nurse and specialist practitioner involvement where required.

Care plans were comprehensive and holistic which promoted the best outcomes for people.

Hospital Passports were in place together with RESTORE2 and TEP records.

Providing information	*Regulations 9, 13 and 17*	**Score (1 -4):**	**3**

We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Where a sensory or cognitive need was identified, AIS compliance was integrated into people's care and support planning, evidenced through communication care plans.

Training was in place for staff and pictorial systems available for staff to use to support people's understanding and provision of information. Large print information was also available if required.

GDPR requirements were followed.

Listening to and involving people	*Regulations 16 and 17 (9, 10)*	**Score (1 -4):**	**3**

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Staff surveys had been completed with positive feedback. Staff also had opportunities to express their views in team meetings and these were minuted.

Residents had opportunities to discuss any concerns with the manager or deputy during their daily walk-around. Resident meetings had not been held for approximately four months but the manager said these would be reinstated soon.

Action Recommended

Information was displayed about how to raise concerns and a complaints policy and procedure was in place, which provided information to residents, families and visitors. There were no open complaints at the time of the visit.

The manager promoted a culture of transparency and this was evidenced through the proactive approach taken to sharing information with external agencies, families and other key stakeholders.

Equity in access	*Regulations 12, 13, 15 and 17 (9, 10)*	**Score (1 -4):**	**3**

We make sure that everyone can access the care, support and treatment they need when they need it.

People were supported to access healthcare professionals if/when they needed to. A GP ward round took place routinely and medications were also reviewed during this time. In the event of an emergency, documentation evidenced prompt and appropriate referral to emergency and out-of-hours services.

The internal areas of the premises and gardens were accessible.

Staff reported they had time to meet people's needs in an unhurried manner.

Equity in experiences and outcomes	*Regulations 12, 13 and 17 (9, 10)*	**Score (1 -4):**	**3**

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

People's care plans provided effective oversight of personal preferences and described how they were supported to achieve positive health outcomes, for example by being able to access health professionals. Regular care reviews involved residents and/or their appointed family members and provided an opportunity to gather feedback. The manager was aware of potential barriers to care and ensured they were addressed and removed as much as possible.

Systems were in place to obtain feedback about people's care and support on a regular basis through monthly care plan reviews, open door policy and daily walkabouts by the manager/deputy manager. Staff feedback was sought through supervisions, meetings and surveys.

Planning for the future	*Regulations 9 and 10 (11)*	**Score (1 -4):**	**3**

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their lives.

Staff had completed end-of-life training. End-of-life care plans were in place but as previously mentioned, lacked detail regarding personal preferences.

TEP and ReSPECT information was documented in care plans. Best interest decisions were in place where needed.

The home worked collaboratively with external professionals, such as GPs and community nurses to support care in end-of-life situations. Consideration had been given to pain management and some people had been prescribed transdermal or oral analgesia.

Actions Identified:
N/A

Actions Recommended:

- Reinstate Resident meetings.

WELL-LED – Leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture			**Good**
The total possible score for WELL-LED is: 28 (excludes sustainability)		**SCORE**	**%**
		21	**75**

4 = Evidence shows an exceptional standard	**3 = Evidence shows a good standard**	**2 = Evidence shows some shortfalls**	**1 = Evidence shows significant shortfalls**

Shared direction and culture	*Regulations 10, 12, and 17 (9) Related 12*	**Score (1 -4):**	**3**

We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

The vision for the service was clearly stated by the manager and deputy manager which was to be the best of care services and to maintain and improve on current good and safe care.

The culture of the service was open, inclusive and transparent. The manager and deputy worked closely together to ensure that daily risks and needs were assessed and reviewed, and outcomes planned proactively. Both managers supported staff development and staff received training to ensure they could deliver safe and effective care that met people's assessed needs.

The effective management of incidents and accidents ensured that risk factors were mitigated where possible. These were reported to the relevant agencies such as Safeguarding, GP, Local Authority and CQC. Medication errors were effectively managed.

A new activity project was being planned called '1000 Dreams Come True' which will aim to fulfil residents' wishes and aspirations. Another project next on the list of improvements was a café area on the ground floor which would offer snacks and refreshments throughout the day.,

The manager stated that the Provider was supportive of continuous improvement and development in line with the vision for the service.

Capable, compassionate and inclusive leaders	*Regulations 6, 7, 18, 19 (4, 5)* *Related 4, 14*	**Score (1 -4):**	**3**

We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

The manager and deputy manager were experienced and skilled in their respective roles and, even though the manager had only been in post for four months, they brought with them many years of experience as a manager.

Staff development was promoted through training that supported individual and team skills and competencies. Leadership was also evident within the team from registered nurses, nursing assistants and team leaders.

Recruitment and induction records evidenced compliance with Schedule 3 and 'Fit and Proper Person' requirements.

Both managers provided compassionate and capable leadership and were clear in their roles and accountability. They operated an open-door policy and were available to staff and residents. Mental health 1st Aiders had been trained and information was displayed with relevant contact names.

Freedom to speak up	*Regulations 10, 12, and 17 (9)*	**Score (1 -4):**	**3**

We foster a positive culture where people feel that they can speak up and that their voices will be heard.

A Whistleblowing policy and training were in place and staff were encouraged in supervisions and team meetings to speak up and share ideas. Reflective learning from incidents and near misses was evident.

The open and inclusive culture of the service encouraged people to feel comfortable speaking up. Residents were supported to give feedback about the service and to bring any concerns or issues to the manager's attention. The manager or deputy carried out a daily walk-about and resident meetings were held previously although needed to be re-instated. Families were welcomed into the home and had opportunities to meet with the manager when visiting.

Workforce equality, diversity and inclusion	*Regulations 17 and 18*	**Score (1 -4):**	**3**

We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Staff who had been recruited under the Sponsorship scheme said they had been well supported to integrate into the team. All staff had access to a full training programme and regular supervision.

Staff human rights were upheld through appropriate policies, employee handbooks and support by the managers and provider.

Governance, management and sustainability	*Regulation 17 (12)* *Related: 14,15,16,18,20,22A*	**Score (1 -4):**	**3**

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Effective governance and organisation structure was evident, with clearly defined roles, responsibilities and accountability. Quality management, systems and reporting processes were in place and effective at identifying issues or concerns. A

comprehensive audit programme included care plans, medication, IPC [quarterly], nutrition, H&S and accidents & incidents as examples. Feedback and findings from these were used to drive improvement.

Workforce planning was evident and the manager and deputy manager made themselves available and monitored and supported the team. Staff were required to complete a wide range of training to ensure their skills and competencies meet the requirements of their job role.

A Business Continuity Plan was in place and used to manage emergency preparedness but did not include climate events [Ref: Safe].

CQC notifications were submitted [with the exception of the aforementioned Grade 3 pressure ulcer]. Safeguarding alerts, incidents and DOLS applications had been made appropriately

Sustainability was evidenced through the well-embedded QA and self-monitoring processes that had been developed and which sat within the wider governance framework. Although a discussion into financial sustainability did not take place, it was apparent through discussion with the registered manager and deputy that investment would continue to support service improvement. For day-to-day expenses, the Compliance manager had the authority to approve spending.

Data protection and GDPR arrangements were compliant with current legislation and guidelines.

The CQC registration and rating poster were displayed.

Partnerships and communities	*Regulations 12 and 17 (9)*	**Score (1 -4):**	**3**

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Documentation evidenced that the service had positive relationships with outside professionals to whom referrals had been made to optimise positive outcomes for residents.

Learning, improvement and innovation	*Regulation 17 (16)*	**Score (1 -4):**	**3**

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

Concerns or issues identified by staff, residents or families appeared to be addressed promptly wherever possible.

The service reflected on findings from incidents, accidents and feedback and these were used to develop learning. There was also evidence of regularly scheduled and documented team meetings and clinical governance meetings to provide feedback and discussion forums for staff.

Environmental sustainability – sustainable development	*Regulation 17*	**Score (1 -4):**	**Not Scored**

We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

This quality statement is not currently being scored by the CQC.

Actions Identified:
N/A

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Actions Recommended:
N/A

End of Report

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REGULATIONS LIST

Health & Social Care Act 2008 (regulated Activities) Regulations 2014

Regulation 4 – Requirements where the Service Provider is an individual	
Regulation 5 – Fit and Proper Persons: directors	
Regulation 6: Requirement where the Service Provider is a body other than a partnership	
Regulation 7: Requirements Relating to Registered Manager	
Regulation 8: General	
Regulation 9: Person-centred Care	
Regulation 10: Dignity & Respect	
Regulation 11: Need for Consent	
Regulation 12: Safe Care & Treatment	
Regulation 13: Safeguarding	
Regulation 14: Meeting Nutritional and Hydration Needs	
Regulation 15: Premises & Equipment	
Regulation 16: Dealing with Complaints	
Regulation 17: Good Governance	
Regulation 18: Staffing	
Regulation 19: Fit & Proper Persons EMPLOYED	
Regulation 20: Duty of Candour	
Regulation 20A: Display of Ratings	

CQC (Registration) Regulations 2009

Regulation 12: Statement of Purpose
Regulation 13: Financial Position
Regulation 14: Notice of Absence
Regulation 15: Notice of changes
Regulation 16: Notification of death of a service user
Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act
Regulation 18: Notification of other incidents
Regulation 19: Fees