

Guild Care

Haviland House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

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

Haviland House is a residential care home providing personal and nursing care to 35 people living with dementia and other health conditions at the time of the inspection. The service can support up to 67 people.

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

Risks to people, including management of particular health conditions, had not always been fully assessed with guidance and information for staff on how to support people safely. There were gaps in the recording of the application of topical creams in some of the medication records reviewed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policy and systems in the service did not always ensure consent was gained lawfully. The use of recliner chairs for some people was a form of restraint, but people had either not been asked for their consent or best interests decisions had not been taken in the use of these chairs. We have made a recommendation to the provider with regard to gaining consent.

Some improvements had been made since the last inspection, but further work was required such as the review of people's care plans and risk assessments. Issues we found at inspection had not been identified by the provider's auditing systems.

People told us they felt safe living at Haviland House. One person said, "Oh yes, I do feel safe and secure. I'm lucky. I have a beautiful view from my room and I do feel safe". There were sufficient staff on duty to meet people's needs and to provide support in line with their choices and preferences.

Dietary needs were catered for and advice sought from healthcare professionals as required. People were positive about the food on offer. One person commented, "I like cooking, but the chefs are fantastic. Today's lunch was very nice; I can't complain".

Haviland House is a purpose-built nursing care home and the premises have been designed to support people living with dementia.

People were treated with dignity and respect by kind and caring staff. One person said, "Staff know me well, we have a good laugh". People were encouraged to be as independent as possible, and their diverse needs were acknowledged and catered for.

People received personalised care that met their needs. The risk of social isolation was mitigated with visits from relatives and friends; social media also enabled people to stay in touch with those that mattered to them. A range of activities was on offer and people enjoyed participating in various events around the

home.

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

Rating at last inspection and update

The last rating for this service was Requires Improvement (report published 5 August 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made and the provider was no longer in breach of one regulation. However, the provider was found to be in continued breach of one regulation and to be in breach of another regulation.

Why we inspected

This was a planned inspection based on the previous rating.

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

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Haviland House

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was undertaken by three inspectors, one of whom was a medicines inspector.

Service and service type

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

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.

What we did before the inspection

We reviewed information we had received about the service which included concerns raised. We looked at statutory notifications which the registered manager is required to send to us by law. We sought feedback from the local authority and professionals who work with the service, including safeguarding investigations which were in progress. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with six people and two relatives about their experience of the service. 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 spoke with the chief executive of the provider who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the registered manager, the director of quality and care home operations, five care staff and the housekeeping manager.

We reviewed a range of records including ten care plans and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to fully identify or assess risks to people and there was a lack of guidance for staff to prevent 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.

Some actions had been taken following the last inspection, including reviewing of people's care plans and risk assessments. However, insufficient improvements had been made at this inspection and the provider was still in breach of regulation 12.

- Recording and monitoring of aspects of people's day-to-day living were inconsistent, and put people at risk of unsafe care. For example, bowel management charts for one person had no entries recorded in the eight days preceding our inspection. This person had a particular health condition and their care plan stated this could cause loose stools with stomach pain or constipation, yet daily monitoring of their bowels had not been consistently recorded. When we brought this to the attention of the registered manager, they told us the person was independent with their bowel management, so daily monitoring was not required. This was conflicting information and could be confusing for staff.
- Another person sustained a high number of falls. Some risks had been identified and assessed, but the person had not had their vision checked since 2018, and poor eyesight may have contributed to their risk of falls. The registered manager agreed this person should be referred for an eye test to have their vision checked by a healthcare professional.
- A third person lived with diabetes which was diet-controlled. Their care plan provided some guidance for staff on the management of the diabetes, but did not include any information on what action they should take if the person had a 'hypo' or 'hyper' incident, when the blood sugar levels were too low or too high.
- For one person who experienced seizures, their care plan did not provide guidance to staff on when to contact emergency services. This meant we could not be assured staff would support this person safely if they became very unwell.
- Some aspects of medicines were not always managed safely.
- Out of eight medication care plans we reviewed, six showed gaps in recording, so it was unclear whether staff were applying people's topical creams as prescribed.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate how risks were managed and there was a lack of guidance for staff. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

- Other aspects of risk management were managed safely. For example, people's risks in relation to COVID-19, or how staff should support them in the event of an emergency, such as evacuating the building, were identified and assessed appropriately.
- Medicines were stored securely and at appropriate temperatures.
- We observed staff giving medicines to people during the afternoon. Staff were polite, gained permission from people, and completed electronic Medication Administration Records (eMAR) after giving each medicine.
- Where medicines were given covertly, that is without people's knowledge, assessments had been completed as needed and best interests decisions were taken.

Learning lessons when things go wrong

- Lessons were not always learned when things went wrong.
- At the last inspection, we identified that some care plans and risk assessments lacked information or guidance for staff. Whilst some actions had been taken to address these issues, such as daily meetings where staff could discuss any concerns about people, further improvements were required.
- The registered manager was aware of the issues and a service improvement plan had been drawn-up and shared with staff to understand what was needed.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse.
- One person told us, "Oh yes I feel safe and if I didn't, I would find one of the staff. They all seem so nice here. I would say something if I needed to". A relative said, "Mum can't tell you if anything has happened because her dementia has taken away her speech. Sometimes she gets anxious, but you can hold her hand and she will relax. I feel she's safe here".
- Staff had completed safeguarding training. One staff member told us, "It's about keeping everyone safe, as anything could happen, not neglecting people or not giving care. Physical abuse is about hitting, marking someone, or restraining them".
- The provider had a safeguarding policy and guidance was available for staff to follow.

Staffing and recruitment

- Staffing levels were sufficient to meet people's needs.
- One person said, "I don't keep track of the days, but there are staff here day and night. I have my call bell and I can press that. I don't usually need to as I have everything I need around me. I can walk, so I would just find one of the staff and ask if I needed anything". A relative commented, "They always seem to have enough staff on my Mum's unit. Staff come into Mum's room and check her, and they know by body language if she needs anything".
- Staff told us that it could become very busy if staff went off sick. One staff member explained, "Rotas are planned, but if staff call in sick, we have to deal with that. We do manage though; it can be challenging".
- The registered manager told us they did not use dependency tools to assess how many staff were required according to people's care and support needs. They said that more staff were allocated to units where people displayed challenging behaviours.
- New staff were recruited safely. All necessary checks were completed, including with the Disclosure and Barring Service to identify whether anyone had a criminal record, two references and verification of employment histories.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 inspection in November 2018 this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

- Records relating to consent to care and treatment were inconsistently completed.
- Some assessments to identify whether a person had capacity to make a specific decision had not been completed, and some decisions had been made without the necessary authorisation. For example, some people used special chairs which provided support for their muscle problems. These chairs were tilted back into a reclining position, so people would not be able to get up independently from the chairs; this was a form of restraint. There were no records or assessments to show how people's consent had been obtained or to reflect that a decision to use the chairs had been taken in their best interests. We discussed this issue with the registered manager at inspection, and they agreed that consent to use the chairs should be gained lawfully.
- In another person's care plan we read that the person should be assisted with personal care, even if they declined. We discussed this matter with the registered manager who assured us that staff would never provide care to a person against their wishes, and that the wording within the care plan would be amended.

We recommend the provider seeks advice and guidance from a reputable source with regard to best interest decision-making and how to implement this in practice.

- Other aspects of consent to care and treatment were managed satisfactorily.
- People told us that staff always asked for their permission before providing support. One person said, "Staff talk to me and ask if I'm okay with what they are doing. I tend to have my little routine which suits me;

I don't feel restricted". Another person told us, "I'm asked if I want any painkillers. Staff sometimes see me struggling and offer".

- Staff had completed training on MCA and DoLS. One staff member explained, "It's about understanding that if people can make decisions themselves, they should do".

Staff support: induction, training, skills and experience

- Staff completed an induction programme and a range of training when they commenced employment at the home. Training was refreshed as needed. Staff had the skills and experience to undertake their roles.
- People felt that staff were trained and equipped to carry out their caring responsibilities. One person said, "They help me when I need them to; they seem to know what they are doing. I am not sure how much training they need to help me". Another person told us, "I don't need help, but I see other people do. The staff know what they are doing".
- Staff commented on the training they had received. One staff member said, "We've done frequent manual handling training, safeguarding, food and fluids, food hygiene, and dementia training. The training on dementia was about vascular dementia and Alzheimer's. We learn about memory loss and about the breaking down of brain cells, the scientific bit".
- Staff told us they received supervision from time to time, and group supervisions were recorded. The registered manager told us that staff received regular supervisions via Microsoft Teams, and these were recorded, but there were no paper records or other proof to show these supervision meetings had occurred. The registered manager agreed that in addition to recording supervisions, these also needed to be documented, and this would be done.

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

- People's needs were assessed before they were admitted to the home.
- Pre-assessments contained information about people's care and support needs, and personalised information relating to their likes, dislikes and preferences. For example, people's nutritional needs were assessed, any dietary needs were identified, and weight was monitored. The Malnutrition Universal Screening Tool (MUST) was used to recognise when a person might be at risk of becoming malnourished.
- People's oral health was assessed and catered for.
- The registered manager stressed the importance of working with families before people moved into the home as information from relatives could provide the basis of the care plan.

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

- People were supported to maintain a healthy and balanced diet and had sufficient to eat and drink.
- People were positive in their comments about the meals on offer. One person said, "Just like home cooking. I don't like fancy food and it suits me here, there is a lot of it. I have snacks when they're brought around and I'm seldom hungry. If I want a drink I just ask, but here in my room there is always a jug full of drink".
- We observed people having their lunch in two dining areas of the home. Staff supported people to eat when needed. Where people required a modified diet, for example, due to swallowing difficulties, this was provided. Assessments relating to people's dietary needs had been completed by healthcare professionals and guidance was followed by staff.

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

- Haviland House is a purpose-built care home and the premises have been designed and decorated to meet people's diverse needs, including people living with dementia.
- Information about people's lives and interests was posted in memory boxes outside their bedroom doors. Bedroom doors were brightly coloured, so people could easily identify which room was theirs. Signage

depicted various parts of the home and included pictures to aid people's understanding.

- Items that might be of interest to people were placed around the home. These comprised items such as books, pictures, hats and puzzles. Corridors included items that reflected people's hobbies, for example, gardening and sports equipment, and a pamper corner.
- Lift doors were brightly decorated and enabled people to access different parts of the home.

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

- People received support from a range of healthcare professionals.
- One person told us, "I would call the doctor myself if I needed, but I don't see him much". Another person said, "They did call the doctor when my hip was bad. I haven't seen a dentist for years, I don't need to as I have good teeth. I suppose I'd only need to ask if I wanted to see one".
- Care records confirmed that people received visits from healthcare professionals. For example, one person's care plan showed they had recently been seen by a paramedic practitioner from the local surgery, and a speech and language therapist had advised on the thickening of fluids, to aid swallowing.
- The registered manager told us that if people had no-one to accompany them to hospital appointments, then staff would go with them to provide support.

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 inspection in November 2018, 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.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's privacy was respected and staff treated them in a dignified and courteous manner.
- One person said, "Staff knock on the door, they don't just barge in. I appreciate that. I would say I am respected, I don't feel otherwise". When asked how staff would promote their independence, this person added, "I do as I please, when I please". Another person told us that staff did not disturb them at night, which was their preference.
- We observed staff encouraging people to be independent around the home. For example, a staff member supported one person to hold the weight of the cup they were drinking from, and assisted them to move their arm to drink independently.
- Another staff member said, "I believe we all respect each other, whether staff or people". They then told us of one person who was born in another country and whose culture was different. The staff member explained they respected people's diverse needs and backgrounds and the importance of being patient with people, and acknowledging differences.
- We observed staff interacting with people and there was a shared sense of humour. Staff were patient, kind and caring in their approach.

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

- People were supported to express their choices and be involved in decisions relating to their care.
- One person said, "I tell staff what I want. They know how I like my tea that sort of thing. Staff always ask if I want to go to bed or when I want to get up. I like to just have female help. Staff are very nice but I like to be private and they respect my wishes". Another person told us, "I make all my choices. I have a wardrobe full of clothes, and some don't fit any more, but I like to keep them. I go to bed when I want and I get up early, but I always have".
- Staff explained how they supported people to express their views. One staff member said, "We tend to talk people through with what we are going to do and we do have a lot of people who decline personal care. We explain the risks of what could happen. If people continue to decline, we can come back later".
- Staff gave an example of one person who met with a professional to discuss mobility aids; they were encouraged to make decisions with regard to what they needed. The staff member said, "It's important to promote [named person] independence and enable her to make her own decisions".

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 Requires Improvement. At this inspection this key question has now improved to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people received appropriate personalised care. During the lunchtime meal, we observed some staff did not treat people with respect; care provided by staff was task-led, rather than orientated to provide people with personalised care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Actions had been taken following the last inspection, and sufficient improvements had been made. The breach of regulation 9 has been met.

- We observed staff supporting and chatting with people at lunchtime. Staff took time to check with people they were happy with the meal on offer and provided support when needed. Staff and people were singing along to music that was playing in the dining room, and chatting about the film where the music had come from.
- People received personalised care that met their needs and was in line with their choices and preferences.
- One person explained that staff were responsive to their needs and said, "Anything I ask for they do. I couldn't ask for better. Like I wanted some more bath stuff the other day and they got it for me the next day".
- Care plans contained information about people, their families and interests. Staff were knowledgeable about people. For example, one person became a little upset in one of the lounge areas and staff suggested they might like a walk around the garden, which they usually enjoyed. The person refused this offer and said they wanted to speak to a relative. Staff reassured them saying they would ring the relative after lunch since they would be at work before then. The person accepted this and appeared to be happy with this solution.

Meeting people's communication needs

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.

- People's communication needs were assessed and met in line with their needs and preferences.
- We looked at one person's care plan which stated they were non-verbal and how they preferred to communicate. Staff knew this person well and explained a translation book, written in the person's first

language, helped each to communicate with the other. Where people had hearing difficulties, staff spoke clearly directing their voice towards people's ears; some people struggled to understand staff because they were wearing face masks.

- Staff provided examples of how they communicated with people. One person would often whisper when responding to staff, and staff would sit close to them to understand what they were trying to say. One staff member said, "We do try and communicate with people, but for one person it's really difficult, as they really don't like staff wearing masks". The person had been offered a mask and apron to wear so they would be similar to staff, and this had worked well.

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

- A range of activities was available for people. Staff supported people to stay in touch with friends and relatives.
- One person's relative was also their essential care giver. Having regular contact with their relative had improved the person's memory. Another relative told us they had brought in a portable CD player for their loved one as they enjoyed listening to music in their room, but could find noise in communal areas too much to cope with.
- Staff told us of the importance of supporting relatives too as they came to terms with the difficult outcomes of dementia and progressive mental deterioration.
- We observed activities happening in various parts of the home. For example, a quiz about well-known phrases and sayings was enjoyed by several people in one of the lounges. People were animated and engaged with the activity and encouraged in this by the staff.
- People's hobbies and interests were recorded in their care plans. One person said, "My daughter visits when she can. We go to the little café and have tea together. I love the gardens here. I am lucky as my room overlooks the garden and I go out there often".
- Relatives and friends were able to visit people in the home, and visits were organised to include relevant COVID-19 checks and testing. The use of social media was also used to enable people to stay in touch with loved ones.

Improving care quality in response to complaints or concerns

- Complaints were managed in line with the provider's policy and to the complainant's satisfaction. Complaints were recorded and showed how lessons were learned and an appropriate outcome was reached.
- One person said, "If I had any complaints I would tell my daughter. She would speak to the management. I have not complained; what is there to complain about?"
- One relative told us of an incident that had occurred several months before when the person was wet because their pad had not been changed. The relative explained their complaint was dealt with promptly and that a similar incident had not reoccurred.
- Staff knew what actions to take if anyone raised a complaint. One staff member said, "A while back, one person made a complaint about some night staff, so we spoke to the staff and sorted it all out".

End of life care and support

- People could live out their lives at Haviland House.
- Care plans included plans for end of life care, and information such as the person's spiritual beliefs, who would visit, who the person would want to be informed about any deterioration in their health and anticipatory medicines.
- Some staff had completed training in end of life care. One staff member told us they would be doing this as part of their Level 3 training and added, "I would like to do end of life training and it would be helpful to

increase my knowledge".

- The registered manager explained the importance of involving family members in any decisions relating to end of life care; conversations should be time-sensitive and comfortable. The registered manager said, "It's a gradual journey, so we talk about it".

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had implemented audits to monitor and measure the care people received, but these were not sufficient to drive improvements.
- Information within some care plans was inconsistent and confusing. For example, for one person, an application had been completed for Deprivation of Liberty Safeguards (DoLS), but some parts of the care plan stated the person was not subject to DoLS. No mental capacity assessment had been completed to support the application for DoLS to show how the person lacked capacity.
- Some information within people's risk assessments was unclear. For example, one risk assessment stated the person should be checked every three hours by staff when in their bedroom. Another risk assessment stated staff should reposition the person every three to four hours. The wrong name had been included within some risk assessments, referring to the person as 'her' for a male resident. We discussed this with the registered manager who concluded this was because information had been copied and pasted from another person's plan.
- Information and guidance for staff in relation to the management of some people's specific health conditions was lacking within care plans. This had been identified at the last inspection, and whilst some improvements had been made to care plans, further actions were needed.
- Information for one person about their time-specific medicines had not been included in their care plan. Seven out of eight people's care plans that were reviewed showed they were prescribed particular medicines such as pain killers and laxatives to be taken on an 'as required' (PRN) basis. However, guidance in the form of PRN protocols or information within care plans was not always in place to help staff give these medicines consistently.
- Staff supervision meetings had not been formally recorded.
- The above issues were shared with the management team during feedback at the end of the inspection, who assured us that actions would be taken to address the shortfalls and for the necessary improvements to be made.

Issues found at this inspection in relation to care plans, risk assessments and need for consent had not been identified through the provider's auditing systems. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We reviewed a range of audits and records regarding the operation and running of the home.

- Audits had been completed on care planning, falls, and medicines management. Every month a trend analysis was completed when people sustained falls, to identify any potential emerging patterns or incidents so that actions could be taken.
- The provider undertook 'mock inspections' which identified areas for improvement and generated action plans. Various actions were then recorded, the name of the member of staff responsible for taking the actions, with a time to complete. Care plans had been identified as in need of improvement and were being reviewed and revamped; this was work in progress.

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

- The provider had made further changes to the management team overseeing the home since the last inspection.
- A service improvement plan had been drawn-up and steps had been taken to address the issues found at the last inspection, and concerns raised by other professionals. As a result, the care and support people received had developed, but further work was required to embed and sustain the improvements made since the last inspection.
- At the last inspection we found that some people's personal information was on display outside their rooms. Confidential information, such as people's dates of birth, has since been removed from public display.
- Notifications received at CQC demonstrated the provider understood and met their responsibilities under duty of candour. The registered manager said, "It's about being open, honest and transparent". They provided us with an example of when a medicines error had occurred and discussing the outcome with the person's family.

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

- People, their relatives and staff were involved in all aspects of the home.
- People were positive in their feedback about the home. One person said, "Staff and their cheery faces make me smile. I like that they are upbeat. Some are so young, but very courteous". Another person told us, "They do most things well, cooking, the chef is great. They are also good at keeping us entertained".
- Staff talked about changes that had occurred at the home, and felt supported by the management team. One staff member said, "I love working here and there have been lots of changes. We don't have as many staff as we used to have, but there aren't so many residents at the moment". Another staff member commented, "Change is good for a fresh perspective. Staff meetings are recorded and put on Teams, so I'll watch the recording if I can't make the meeting. I have good relationships with managers and feel supported".
- Communication had been an issue previously. For example, when relatives had tried to call the home, the telephone went unanswered. The registered manager said communication had been improved and now every unit within the home had a separate email address and mobile phone.
- Relatives' meetings were held every month and various matters were discussed. For example, a recent outbreak of diarrhoea and vomiting had affected some people at the home and this was talked through with relatives. One relative said, "It's been a bit weird visiting-wise because of COVID-19. What I love here are the big corridors for people to move around and that was the main thing for me, that Mum can use her frame and move around. They did their utmost to accommodate relatives during the pandemic and as soon as they could, they offered timetabled visits".

Working in partnership with others

- The home worked in partnership with a variety of professionals.
- The home had received support from health and social care professionals recently. On the day of our inspection, two people from the local authority's contracts and commissioning team were undertaking a monitoring visit.
- The registered manager shared information with managers from the provider's other services. They were a member of the managers' forum on Skills for Care which helped them to share information and keep updated on current guidance.

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
Treatment of disease, disorder or injury	Care plans lacked information on how risks were managed and there was a lack of guidance for staff. This placed people at risk of harm. Regulation 12 (1)(2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure that auditing systems were sufficiently robust to monitor and measure all aspects of the service effectively. Regulation 17 (1)(2)