Sonnet Care Homes (Essex) Limited

The New Deanery Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: The New Deanery is a residential care home that was providing personal and nursing care to 68 people aged 65 and over at the time of the inspection.

People's experience of using this service:
People told us they felt happy and safe living at The New Deanery. People told us there was a wide range of activities and they were supported by kind, compassionate staff who took a real interest in them. People told us, and records confirmed, they were given plenty of opportunities to provide feedback about their care, and the provider acted on any concerns they raised. People spoke very highly of the standard of decoration in the home and the quality of the gardens which were well maintained and well used by people. People and relatives told us they appreciated the range of different spaces within the home where they could meet with visitors and spend time.

Some people were less positive about their experience of care, and we found this reflected the inconsistencies we found in the quality of care plans and risk assessments. Some risk assessments and care plans were less personalised, detailed and up to date and this meant there were risks that people did not always receive personalised care. Assessments did not consider the impact people's sexual and gender identity may have on their care. We have made a recommendation about this.

People told us staff supported them to attend medical appointments and to take their medicines. The provider updated medicines information in response to issues we found during the inspection.

People were supported by staff who understood the values of the organisation, and had received the training and support they needed to perform their roles. Staff felt valued and were rewarded when they demonstrated the values of the organisation.

There were various different audit and quality assurance systems in place. These had not always operated effectively and had not identified the issues we found during the inspection with medicines information and the consistency of care plans. The provider had not submitted notifications to us as required by law.

The provider worked closely with the local authority quality improvement team and other organisations to keep up to date with best practice in the field. They were piloting new technology and systems to support people to maintain their independence.

Rating at last inspection: The service was rated Good when it was last inspected in August 2016.

Why we inspected: This was a scheduled inspection.

Enforcement: Please see the end of the full version of this report for details of the actions we told the provider to take.

Follow up: We will require an action plan and will closely monitor the service. We will return to complete a further inspection in line with our published policies and procedures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

See details in our Safe findings below.

Is the service effective?

Good

The service was effective.

See details in our Effective findings below.

Is the service caring?

Good

The service was caring.

See details in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

See details in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

See details in our Well-Led findings below.

The New Deanery Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by two inspectors, two assistant inspectors, a directorate support coordinator and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts had personal experience of caring for someone who uses this type of service.

Service and service type:
The New Deanery 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, 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:
The inspection was unannounced.

What we did:
Before the inspection we reviewed the information we held about the service in the form of notifications they had submitted to us and feedback from members of the public. Notifications are reports of incidents

and events that take place within services that providers are required by law to tell us about.

The provider had submitted a Provider Information Return. This is information providers must send us to give us key information about the service, what it does well and improvements they plan to make. We took this into account in planning our inspection and making our judgements in this report.

During the inspection we spoke with 23 people who lived in the home, six relatives and two visitors. We spoke with five care assistants, three senior care assistants, a housekeeping supervisor, the chef, the activities coordinator, the deputy manager, the registered manager, the administrator and the chief executive. We reviewed the care files for nine people, as well as medicines and activities records. We reviewed eight staff files including recruitment and supervision records as well as the training records for the home. We reviewed various meeting minutes, audit reports, activities records, menus and action plans as well as other documents and policies relevant to the management of the service.

After the inspection the provider sent us documents and policies as requested during the inspection.

Requires Improvement

Is the service safe?

Our findings

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

RI: 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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

● One person told us they did not always feel certain staff knew how to support them safely when they needed support with moving and handling. One person said, "They [staff] didn't know how to use [piece of equipment]. I had to tell them each stage. I had to be the instruction book." However, other people told us staff were confident in using their equipment and made them feel safe when doing so. One person said, "They know how to transfer me. They talk me through each bit so I know what to do next. I feel very safe with them."

● The variation in people's experience was reflected in the quality of their written risk assessments. The person who said they did not feel safe did not have a risk assessment in place for their equipment. Their file noted they now used this equipment in a review, but there was no specific risk assessment for it.

● Other risks faced by people had not been assessed and mitigated. For example, one person's file contained a note that they experienced suicidal thoughts. There was no risk assessment in place regarding their mental health or suicidal thoughts. Another person had medicine prescribed for severe allergic reactions. The only information regarding this was that the allergen was listed in their medicines care plan. There was no risk assessment in place about how to mitigate the risks of an allergic reaction, and no personalised detail of how to identify and respond to the person having an allergic reaction. A third person's personal evacuation plan stated they would be alerted to a fire emergency by "hearing the alarm" despite the fact this person was deaf. This person also had a visual impairment that would affect their ability to evacuate safely. The plan stated they would need the assistance of a member of staff to evacuate but did not describe what this assistance looked like.

● The provider used standard tools to calculate people's risks regarding nutrition and skin integrity. However, these were not always correctly completed. For example, one person's falls risk assessment had been incorrectly totalled, and records appeared to show it was the person's first three days in the home despite them having lived there for three months.

The above issues with the inconsistency and incompleteness of risk assessments was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were other examples where risks had been well identified with clear monitoring and mitigation plans in place. The provider used robust systems for monitoring falls to identify patterns and consider different measures that may mitigate risks of falling for people.

● People told us they felt safe as they had personal alarms and call bells.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe with staff. Staff were knowledgeable about the steps they should take if they

suspected anyone living in the home had experienced abuse.
● Incident reports showed the provider was not routinely identifying incidents as safeguarding alerts. For example, they had completed an investigation into an allegation of neglect which had led a person experiencing pain but they had not identified this as a safeguarding alert or raised it with the local authority. This was raised with the provider who told us the registered manager had judged the incident to be highly unusual with no prolonged impact, so they had not raised it as a safeguarding alert but had investigated it under their duty of candour. This meant the registered manager had not followed the local safeguarding procedures and had not appropriately identified this was an allegation of neglect. The provider submitted appropriate notifications following the inspection.

Staffing and recruitment
● Records showed the service followed robust recruitment processes that ensured staff were suitable to work in a care environment.
● The provider calculated the staffing levels based on the dependency needs of people living in the home. Monthly monitoring reports showed they deployed more hours than were calculated as needed by their dependency assessments. During the inspection additional staff attended the home and people told us there were not normally this many staff on duty.
● People told us there were enough staff to meet their needs, but that they felt staff were rushed and did not have time to chat and spend time with them outside of when they were delivering care. One person said, "Not really [enough staff], they could do with more. They rush around all the time. When they help me do something in my room we chat. They're too busy to sit down with me." Another person said, "They usually chat when they are going to do something for me like washing me in the morning." A third person said, "They don't really have the time now. They talk when they're 'doing' me but I think they are short-staffed." Another five people told us they did not feel staff had time to sit and chat with them outside of providing care.
● We spoke to the registered manager and provider about this feedback and they told us they would explore it with staff and people at their next meetings. We will check with people at our next inspection whether they feel there have been improvements in how staff spend their time with them.

Using medicines safely
● People told us staff supported them to take their medicines on time. Staff administered medicines in a patient and caring way, ensuring people knew what they were taking and were taking it in a safe way.
● Care files contained information about people's medicines, what they were for and any side effects to look out for.
● Records showed people were supported to take their medicines as prescribed.
● People were prescribed medicines on an 'as needed' basis such as pain relief. The guidance in place to inform staff when to offer and administer these medicines was insufficient. The guidance simply repeated the prescribing instructions and did not state how to identify how a person may express pain or how to decide how much of a variable dose to administer. The provider responded to this feedback by updating the guidelines and sending them to us. The updated guidelines informed staff how to identify when to offer and administer these medicines. We will check these improvements have been sustained when we next inspect the home.

Preventing and controlling infection
● People told us staff cleaned their rooms and en-suite bathrooms regularly. We saw the home was clean and free from any mal-odours. Housekeeping staff followed infection control practices to reduce the risks of the spread of infection and cross contamination when cleaning the home.
● The provider monitored the number and level of infections people within the home had in order to ensure

that any outbreaks were identified and addressed in a timely manner.

Learning lessons when things go wrong

● Responses to individual incidents were robust and personalised. For example, where people had fallen this had prompted a review of their care plans with additional measures such as equipment or referral to healthcare professionals considered. Where a person had a fall whilst carrying out a puzzle activity the actions had considered how to reduce the overall risk of falls, as well as how to enable them to take part in these types of activities safely in the future.

● Incidents reports, falls, infection levels and other concerns were reviewed and discussed at monthly governance meetings. These identified lessons to be learned to avoid a recurrence and ensured these were cascaded to the teams.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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

- Care plans contained evidence of assessments being conducted before they came to live at the home. Initial assessments covered risks and preferences in areas such as nutrition, skin integrity and routine. Risk assessments were in nationally recognised formats with tools used to assess risks of malnutrition and skin integrity.
- Although none of the people we spoke with recalled being involved in meetings about their care, they did all say they had told staff members about their needs and preferences. Family members confirmed they had been involved in the assessment process before their relatives moved into the home.
- Records showed needs assessments considered people's religious beliefs and cultural background as part of the assessment process. However, there was no consideration of people's sexual orientation or gender identity and the impact this may have on care preferences as part of the assessment process. Staff confirmed they did not explore this with people before they moved to the home. This meant there was a risk that people may not feel safe to disclose their sexual or gender identity as the service was not clearly demonstrating they had a welcoming approach.

We recommend the service seeks and follows best practice guidance about supporting people around their sexual and gender identity.

Staff support: induction, training, skills and experience

- Staff told us, and records confirmed they received regular supervisions and appraisals. The frequency of supervision varied depending on the level of experience of staff members. Those who were newer in post had supervision each month, those who were more experienced had it every three months. Staff spoke highly of the supportive nature of supervisions and said they could request support and adjustments to their working patterns through supervisions.
- The provider had continued with their values based induction training for new staff. This included that new care assistants spent a day with the activities team before delivering care so they could get to know people. We saw the governance team was considering whether induction should also include a day working with the laundry team to help care workers understand the pressures of working in the laundry.
- Staff who were new to working in a care setting were supported to complete the care certificate. The care certificate is a recognised qualification that provides staff with the fundamental knowledge required to work in a care setting. Staff then completed refresher courses.
- The provider's training records showed most staff were up to date with their required training. Where staff training was out of date this was known by the management team and plans to increase staff training compliance were discussed in the monthly governance meetings.

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

● People gave us mixed feedback about the meals. Some people were very positive, for example, one person said, "It's very good, if you fancy anything you just tell them and they will get it for you." However, other people told us they did not find the food appetising and two people who ate in their bedrooms told us their meals were cold. One of them said, "No [I don't like the lunch] when I uncovered it did not look very nice, and it's not all that hot"

● Lunch was served in a large dining room, where staff wrote people's choices down on small notebooks as if they were restaurant staff. There was a relaxed and pleasant atmosphere as people at their lunch.

● The registered manager told us how they did additional shopping trips each week to make sure people's preferences were met.

● Care plans recorded people's favourite foods and nutritional needs and records showed these were met. Where one person's care plan recorded that they liked to eat salads and tomatoes, records showed they were regularly served these types of foods. Another person had been assessed as requiring soft foods due to swallowing difficulties and this was detailed within their care plan. Where the person had expressed a dislike of this texture of food, records showed staff had requested a review of this from a healthcare professional.

● People were weighed regularly and the provider had systems to monitor their weights on a monthly basis. People's weights were recorded and included in a monthly clinical report so that any increase or decrease could be identified and acted upon swiftly. Records showed that where one person had been under the care of a dietician due to weight loss, their weight had steadily increased following measures in place.

● There was a menu on display throughout the service which showed a choice of two meals each day with a list of alternatives that catered to a variety of tastes. Alternative choices included salads, omelettes, pizzas or chips.

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

● People's bedrooms had been decorated to a high standard and had been personalised with people's photographs and possessions.

● Communal areas of the home had also been decorated to a high standard. There was a café where people could go to have tea and cake with other people and their visitors. There was also a bistro café area as an alternative space for people to gather. There was a large room with a piano which we saw was used for a church service during our inspection.

● The service carried out appropriate health and safety checks to ensure the building was suitable and well maintained.

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

● People told us staff would support them to access healthcare services and attend appointments when they needed.

● Care records contained evidence of ongoing involvement of healthcare professionals. For example, one person had a medical condition that required regular reviews from a consultant. Their care plan detailed how the condition affected them and we saw evidence of staff attending appointments with the person and recording the outcome.

● Another person's care records showed how staff had identified changes to their behaviour and wellbeing which they had been referred to the GP to test for infection. Staff documented the visit as well as their contact with the GP to chase the outcome of the results.

● Although most health information was clearly recorded, we found one person's records captured a steady and consistent decline in their mental health. We spoke about this with the registered manager who told us they would re-refer this person to mental health services in response to our feedback.

● The service was working with the local authority quality improvement network. This meant the provider

used quality improvement approaches to make changes to reduce falls, pressure ulcers and infections within the home.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Most people living in the home had full capacity to consent to their care, and no one was subject to restrictions that would amount to a deprivation of their liberty.
- People told us they were asked permission by care staff before delivering care and records showed people had consented to their care. Where people had appointed decision makers to support them with certain decisions the home had clear records of this.
- One person's care file contained conflicting information about their capacity. This was discussed with the registered manager who advised the paperwork stating they lacked capacity had been completed when they had been suffering with an acute illness and was no longer accurate. They told us they would re-visit this document with the person to ensure it reflected their current preferences.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People got on well with the staff who supported them. Throughout the day we observed positive caring interactions between people and staff. In the morning, one person had specifically asked to say hello to one member of staff. The staff member arranged to swap duties briefly to enable them to greet this person.
- People told us staff were kind and treated them with compassion. One person said, "They [staff] are friendly and cheerful. They make me happy. We share our lives and they are like friends." Another person said, "They are like family. They always ask about my son and what's been happening in my family. We share stories. I feel very close to some of them."
- Staff spent time with people and created a positive atmosphere. We observed staff reading a magazine with two people and discussing an article within it, which created a pleasant and engaging atmosphere in the room.
- People described how staff demonstrated their respectful attitude. One person explained, "They are polite. They always knock before they come in to my room. They ask me what I want to do, they don't push me to do things. If I want to go downstairs they don't stop me." Another person said, "They knock on the door even when it's open. They don't assume anything."
- The service made provision for representatives of different Christian denominations to visit the home to meet people's faith needs. No one living in the home had a faith that was not Christian, but the activities coordinator told us they had contact details for other faith groups in the local area should someone of a different faith move to the home.

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

- Care plans contained detailed life stories in which people had been given opportunities to tell staff all about their backgrounds and what was important to them. This had enabled people to express preferences and be involved in care planning. One person had told staff about their routine and how they liked to stay up late, this information had been added to their night care plan to say they liked to get up late. We observed this person being supported to get up and have a cup of coffee later in the morning, as outlined within their care plan.
- Although the home had identified people's interests and captured information about their pasts, people gave us mixed feedback about how this information was used. For example, one person was a keen and accomplished knitter though they said staff had only taken an interest after they had offered to make a blanket for them. Two other people whose care plans contained a life story both told us they didn't get asked about their hobbies or pasts. One of them said, "No one ever comes in and ask me about my past, I could tell them because it's all in my brain."
- People and relatives told us the home supported them to stay in touch with each other by telephone. We saw visitors were welcomed and able to see their friends and family in private if they wished. People and

their visitors told us there were plenty of places for them to spend time, and the garden was particularly pleasant in the summer.

Respecting and promoting people's privacy, dignity and independence

● Staff told us how they ensured people's dignity was upheld while receiving support with care tasks. People confirmed staff took care to ensure their dignity was preserved.

● Care plans described which aspects of care tasks people could complete independently which encouraged staff to ensure people's skills and independence was maintained.

● People told us staff supported them kindly and did not over support them or limit their independence. Although one person said a member of staff had spoken for them at a health appointment which had made them feel "A bit invisible." They recognised this member of staff had been inexperienced and this had not happened again.

Requires Improvement

Is the service responsive?

Our findings

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

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People told us they received personalised care from staff who checked their preferences and ensured they were offered choices on a daily basis.
● Although none of the people we spoke with could specifically recall having meetings to discuss, plan and review their care people's views were captured in their care files. Staff told us they checked with people regularly if they were happy with the care their received. Monthly reviews and keyworker summaries were recorded by staff which considered if people's needs had changed or any significant events in the month.
● The activities coordinator had recently won a national award for their passion for providing activities. They facilitated a wide range of activities including various quizzes that people told us they enjoyed. They supported people to attend activities in the community including visits to the theatre, the ballet and cafes. They had recently established a group for men living in the home in recognition that activities on offer tended to be more suitable for women. There was a full timetable of activities on offer which changed each week. Activities were planned based on people's feedback and requests.
● People told us and we saw staff delivered care and support in a personalised manner, reflecting people's individual choices and preferences. However, the detail of the support we saw being delivered was not always captured in people's care plans. For example, one person's care plan stated they had anxiety but there was no detail about how to support them to manage this. Another person had recently moved bedrooms but the reasons for this, and the support they may require to orientate themselves was not captured within their file.
● Other care plans were highly personalised with details of how people liked to be supported including details of their preferences for which products to use and the order of care.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy which included details of how people could make complaints.
● People told us they would feel confident to raise any concerns or complaints with any member of staff. Relatives also told us they would raise any issues with staff and were confident they would be addressed.
● Records showed there had been one formal complaint in the last year which had been appropriately investigated and responded to.
● The provider also collected feedback from people individually and through meetings with people and their relatives. These were used to make changes to the service provided and to drive improvements.

End of life care and support
● The service was working towards achieving the Gold Standard Framework (GSF) for end of life care. This is a recognised framework to ensure people are appropriately supported as they approach the last stages of their life. It involves monitoring and planning to ensure people are receiving the correct support and the right time.

● There was significant variety in the quality of end of life care plans within the service. Some people had detailed plans which included who they wanted to be with them in their last days, what music they would like playing and what aspects of treatment they would and would not like. However, other plans had not been well developed. Some simply stated that people wished to stay in the home and be supported to be pain free, with no detail of how they wished to receive care. Another plan stated that family members knew what the person's wishes were, but did not say what these were. The provider told us they were in the process of updating their end of life care plans as part of their work towards achieving the GSF framework. We will follow up on these improvements at our next inspection

Requires Improvement

Is the service well-led?

Our findings

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

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Providers are required by law to notify CQC of certain types of event and incidents. These include injuries sustained by people receiving care and any allegations of abuse or neglect. During the inspection we found allegations of neglect and abuse being investigated, and records of injuries sustained which had not been reported to us. The registered manager told us they had not realised this type of injury needed to be notified to CQC. They had not identified the allegation of neglect as a safeguarding concern and although they had completed a robust investigation they had not reported it to the local authority or to CQC. The provider told us this was because they had judged the impact to be minor and the incident to be a one-off occurrence. After the inspection the provider submitted the notifications for incidents identified during the inspection.

The above issues of failing to notify CQC of events is a breach of Regulation 18 of the CQC (Registration) Regulations 2009.

● The provider had a system of audits and checks of records and care files. However, these had not identified the inconsistencies we found in the records we checked. A senior member of staff checked a sample of files each month. These audits had not identified where information contained in reviews and updates had not been incorporated into the care plan or risk assessment.
● Weekly medicines audits were completed. These included a section regarding guidelines for medicines prescribed on an 'as needed' basis. As described in the safe domain the provider had to take action to improve these guidelines in response to our inspection findings. We reviewed 47 medicines audits none of which identified that the protocols in place were insufficient. This meant the audits were not operating effectively to identify issues with the quality and safety of the records.
● We checked call bell audits and response times were consistently over five minutes with regular waiting times exceeding ten minutes. People had told us they had to wait between five and ten minutes for staff to respond to their call bells. Despite being regularly audited, the checks did not identify the reason for these response times and no additional actions were being taken to address this issue. Information about increased audits was shared with people and their relatives as they had raised this in feedback surveys.

The above issues regarding the effectiveness of audits are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider held monthly clinical governance and oversight meetings. The registered manager presented

a summary report of infections, falls, incidents, injuries, weight loss or gain and provided an update regarding staffing in the home. The reports and minutes of the meetings showed there was a detailed understanding of the needs of people living in the home and the issues that required active management from the senior management team. Governance meetings considered the impact of wider social and political events on the service and ensured an ongoing risk register was maintained.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider's values of Kindness, Comfort and Respect were embedded throughout the service. Staff knew the values and this was a reflection of the training and induction approach of the provider.

● People and relatives told us the registered manager would speak with them regularly and check they were happy with their care. They told us the registered manager would do a weekly shop to pick up things that they were not able to get while they lived in the home. This included vegetables, special biscuits and sweet treats.

● The registered manager kept a record of the "thousand little things" that they captured to demonstrate the little things that add up to a personalised care service. These included supporting one person to visit flats and ensuring another person had films to watch to distract them from their concerns about electricity wastage.

● The provider met their duty of candour obligations, acknowledging where things went wrong and offering apologies appropriately.

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

● People told us they had regular meetings and took part in surveys about their care. One person said, "We get a survey sometimes. We do meet sometimes, one of the mangers comes too and we talk about things, what activities we like and are we happy." People told us, and records confirmed people spoke about activities, laundry, food and other aspects of communal living. The provider considered any negative feedback received during these meetings and where appropriate, added their response to the home's improvement plan. The response to the survey was overwhelmingly positive.

● Staff told us, and records confirmed, they had regular meetings. Staff consistently told us these were used to talk about the people living in the home and any changes to their needs, feedback from people about their care, as well as to ensure staff were up to date in their training. Staff provided feedback about training and networking events they had been to.

● Staff told us, and we saw posters on display which confirmed, there were regular awards to staff who went above and beyond to demonstrate the values of Kindness, Comfort and Respect. The award had recently been given to a staff member who had taken someone out in their convertible car so they could feel the wind in their hair. The smiles in the photos showed both the staff member and the person had enjoyed their trip out.

Continuous learning and improving care; Working in partnership with others

● The provider worked closely with the local authority's quality improvement approach to supporting people in care homes. It was clear they engaged with these systems and implemented them at a local level. This was demonstrated through examples like the falls monitoring tools in place.

● The provider was seeking innovative, and less intrusive ways of monitoring people who were at risk of falls. In response to the fact that many people living in the home remained very independent, and reluctant to use traditional falls prevention equipment such as frames and sensor mats, the home had trialled different technological monitoring systems to mitigate people's falls risks.

● Staff were supported and encouraged to attend conferences and other events where they learnt about

innovations and developments in the care home sector. Staff provided feedback about these events in staff meetings. In recognition that some people receiving care only received touch in a clinical or task focussed way, some staff were completing a reflexology course which would give them skills to be able to ensure people had "non-clinical" touch in their lives.

● The provider maintained both a clinical governance action log and a heads of department action log to ensure progress on improvements and developments in the home was both monitored and maintained.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of events as required. Regulation 18(1)(2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks faced by people had not been consistently identified or mitigated against. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)(a)(b)