Little Court Care Home Limited

Little Court Nursing Home

Inspection report

26 Roopers
Speldhurst
Tunbridge Wells
Kent
TN3 0QL

Date of inspection visit:
07 May 2019

Date of publication:
03 June 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Little Court Nursing Home is a residential care home providing accommodation, nursing and personal care for 35 older people. At the time of this inspection 32 people were living in the service.

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

People's experience of using the service:
People were positive about the service. A person said, "I've got what I need here and I'm okay."

People were safeguarded from the risk of abuse.

People received safe care and treatment in line with national guidance from nurses and care staff who had the knowledge and skills they needed.

There were enough nurses and care staff on duty to meet people's needs and medicines were managed safely.

Lessons had been learnt when things had gone wrong.

People had been helped to receive medical attention when necessary.

People and their relatives were consulted about the care provided and their consent had been obtained.

Nurses and care staff were courteous and polite and confidential information was kept private.

Equality and diversity was promoted and people were supported to pursue their hobbies and interests.

There were robust arrangements to manage complaints.

People were treated with compassion at the end of their lives and supported to have a pain-free death.

People and their relatives had been consulted about the development of the service and quality checks had been completed.

Good team work was promoted and regulatory requirements had been met.

Rating at last inspection:
The service was rated as 'Good' at the inspection on 31 October 2016 (the inspection report was published on 12 December 2016). At this inspection in May 2019 the overall rating of the service has been maintained

as 'Good'.

Why we inspected:
This was a planned inspection based on the rating we gave the service at the inspection in October 2016.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit in line with our re-inspection programme. If any concerning information is received 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?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Little Court Nursing 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 as part of our regulatory functions. This inspection checked whether the registered persons are meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
We visited the service on 7 May 2019.

Inspection team:
The inspection was completed by an inspector, a specialist professional advisor and an expert by experience. The specialist professional advisor was a nurse. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Service and service type:
Little Court Nursing Home is a care home that provides accommodation, nursing and personal care for 35 older people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Notice of inspection:
This inspection was unannounced.

What we did:
We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service. This included notifications of incidents that the

registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We Invited feedback from the commissioning bodies who contributed to purchasing some of the care provided by the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes. This information helps support our inspections.

We spoke with 12 people living in the service.

We spoke with five care staff, the head of care and one of the activities coordinators. We also spoke with the administrator, maintenance manager, registered manager and the chief executive officer of the company who ran the service.

We reviewed documents and records that described how care had been provided.

We reviewed documents and records relating to how the service was run including health and safety, the management of medicines, staff training and obtaining consent.

We reviewed the systems and processes used by the registered persons to assess, monitor and evaluate 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 cannot talk with us.

Good

Is the service safe?

Our findings

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

Safe: People received safe care and treatment.

Supporting staff to keep people safe from harm and abuse, systems and processes:
• People were safeguarded from situations in which they may experience abuse. Nurses and care staff had received training and guidance. They knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. A person said, "The staff are lovely actually and I like them all."
• The registered manager had an audit tool that was used to list any concerns raised with them. They used the tool to ensure there was a detailed account of the action they had taken including notifying the local safeguarding authority and CQC.

Assessing risk, safety monitoring and management:
• Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected.
• When risks to a person's health and safety had been identified steps had been taken to reduce them. An example of this was people being provided with low-rise beds that made it easier and safer for them to get up and go to bed.
• People received safe care. This included people who needed extra help due to having reduced mobility. We saw two care staff using a hoist in the correct way to help a person change position. Nurses and care staff supported people in the right way to keep their skin healthy. This included making sure people did not develop sore areas and quickly seeking medical advice if they did. Nurses and care staff also assisted people in the right way to promote their continence including correctly using aids.
• People had been helped to avoid preventable accidents. Hot water was temperature-controlled and radiators were fitted with guards to reduce the risk of scalds and burns.
• The service was equipped with a modern fire safety system that was designed to enable a fire to quickly be detected and contained so people could be moved to safety. In April 2019 the local fire safety authority had recommended that a limited number of improvements be made to enable the service's fire safety system to comply fully with national guidance. The chief executive officer showed us documents and receipts showing that the necessary improvements were about to be made. We noted that in the interim they had taken suitable action to maintain an appropriate level of fire safety protection in the service. An example of this was responding to the fire authority's advice that fire resisting bedroom doors should not be wedged open. We saw that new and approved hold-open devices were about to be installed to address the problem. Until this had been done nurses and care staff had been reminded not to wedge open fire doors. During our inspection visit we did not see any fire doors wedged open.

Safe use of medicines:
• People had been helped to manage medicines in line with national guidelines. There were suitable systems for ordering, storing, dispensing and disposing of medicines.

• Nurses had received training and had been assessed by the registered manager to be competent to safely support people to take medicines. There were guidelines for nurses to follow that said when and how each person needed to take medicines. Nurses followed these guidelines and supported people to take medicines in the right way.
• There were additional guidelines for nurses to follow when dispensing variable-dose medicines. These are medicines that a doctor had said could be used when necessary. An example of this was medicines used for pain relief.
• Nurses completed a record of each occasion on which they assisted a person to take medicines. The registered manager regularly audited these records and checked the medicines held in stock to make sure medicines were being managed in the right way.

Staffing and recruitment:
• The registered manager had calculated how many nurses and care staff needed to be on duty. When doing this they had considered the care needs of the people living in the service. This included whether a person needed nursing care for a specific medical condition. Also, whether a person needed two care staff to assist them due to experiencing reduced mobility.
• Records showed that sufficient nurses and care staff were routinely on duty to provide people with the nursing and personal care they needed. We saw people promptly being assisted to undertake a range of everyday activities including using the bathroom, going to and from their bedroom and enjoying the garden. A person said, "I get a lot of help from the staff and they always seem to be around when I need them." Another person spoke about how promptly care staff responded when they rang their call bell and said, "Yes, they always answer."
• Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct. Nurses were required to demonstrate that they were registered with their professional body.

Preventing and controlling infection:
• There were measures to prevent and control infection. There was written guidance for nurses and care staff to follow in how to reduce the risk of infection. They had received training about the importance of good hygiene and knew how to put this into practice. Nurses and care staff correctly described to us the importance of regular hand washing.
• Nurses and care staff had been provided with antibacterial soap and with disposable gloves and aprons.
• There was an adequate supply of cleaning materials. Housekeepers followed a plan to ensure that all areas of the service were regularly cleaned.
• Fixtures, fittings, furnishing, mattresses and bed linen were clean.
• The registered manager had completed regular audits to ensure that suitable standards of hygiene were maintained in the service. A recent audit had identified that a small number of improvements needed to be made. Plans were in place to quickly address the shortfalls and action had been taken in the interim to reduce the risk of infection. An example of this was some of the commodes being of an older design. Their frames were made of wood rather than more readily cleanable plastic. Until new plastic commodes were delivered to the service, the housekeepers were spending extra time cleaning the older wooden frames to ensure that they were in a hygienic condition.

Learning lessons when things go wrong:
• The registered manager used an audit tool to check that accidents, near misses and other incidents were promptly analysed. This was so that lessons could be learned and improvements made. The audit tool contained information about what had happened and the causes. This was so that trends and patterns

could be seen. An example was the audit tool being able to identify the location where a person had fallen to indicate if it would be helpful to rearrange the furniture in that room to remove any obstructions.
• When things had gone wrong suitable action had been taken to reduce the likelihood of the same thing happening again. This included consulting with a person's relatives and requesting assistance from healthcare professionals. An example was nurses arranging for a person to see their doctor if they appeared to have become unsteady on their feet due to being unwell. A person said, "Oh the staff keep an eye on me and make sure I'm okay. I find that quite reassuring because the staff really do care about us all."

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 experienced positive outcomes from care delivered in line with national guidance.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The registered manager had assessed each person's needs for care before they moved into the service. This was to make sure that the service could reliably provide the care each person needed to achieve effective outcomes in line with national guidance. The assessments considered if people needed to use special equipment such as hoists and easy-access baths. They also noted if a person had a healthcare condition requiring items such as special dressings.
• The assessment had also established what needed to be done to meet people's expectations by respecting their protected characteristics under the Equality Act 2010. An example of this was respecting a person's cultural or ethnic heritage by enabling them to choose the gender of the nurses and care staff who provided their close personal care.

Staff skills, knowledge and experience:
• New nurses and care staff had received introductory training before they provided people with care. Care staff had completed training that was equivalent with the Care Certificate. This is a nationally recognised system to ensure that new care staff know how to care for people in the right way.
• New nurses and care staff had also completed a number of 'shadow shifts' to observe and learn from a more experienced colleague.
• Nurses and care staff had also received refresher training to keep their knowledge and skills up to date. The subjects covered included how to safely assist people who experienced reduced mobility, promoting people's continence and emergency first aid. Nurses had completed additional training in how to manage healthcare conditions such as epilepsy, diabetes and pressure ulcers.
• Nurses and care staff had regularly met with a senior colleague to review their performance and promote their professional development.
• Nurses knew how to care for people in the right way. Examples of this was nurses knowing how to correctly use medical appliances and special dressings. Examples relating to care staff included them knowing how to support people to maintain good oral hygiene, use hearing aids correctly and put shoes and slippers on securely.

Supporting people to eat and drink enough with choice in a balanced diet:
• People were helped to eat and drink enough. Kitchen staff prepared a range of meals that gave people the opportunity to have a balanced diet. People had been consulted about the meals they wanted to have. A person said, "The food is pretty good and certainly we always have more than enough."
• People could dine in the privacy of their bedroom if they wished. In the dining room. the tables were neatly laid with fresh table cloths, clean cutlery and attractive place settings.
• When necessary, people who needed help to eat and drink enough were assisted in the right way. We saw

care staff sitting beside people at lunchtime gently helping them to use cutlery and cups.
• People's weights were being monitored and nurses had liaised with doctors and dietitians when they had concern that a person might not be eating or drinking enough. When necessary people were being offered food supplements to help maintain their weight. Nurses had also contacted speech and language therapists when people were at risk of choking. This had been done to establish if a person's food needed to be prepared in a particular way. Nurses and care staff were following the advice they had been given. This included some people having their food blended and drinks thickened so that they were easier to swallow.

Staff working with other agencies to provide consistent, effective, timely care/ Supporting people to live healthier lives, access healthcare services and support:
• Nurses and care staff supported people to receive coordinated care when they used or moved between different services. An example of this was nurses liaising with hospital staff when a person was admitted to hospital. This was done to pass on important information about a person's nursing and personal care needs so that hospital staff could meet these in the right way.
• Nurses had also promptly arranged for people to see their doctor if they became unwell. They had also arranged for people to see healthcare professionals such as occupational therapists, opticians and chiropodists.

Ensuring consent to care and treatment in line with law and guidance:
• The Mental Capacity Act 2005 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 make 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 the Act's application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• People had been supported to make everyday decisions for themselves whenever possible. Examples of this were people being asked about what drinks they wanted to have, what clothes they wanted to wear and when they wanted to be assisted to rest in their bedroom.
• The registered manager had ensured that decisions were made in each person's best interests. This included consulting with relatives and healthcare professionals when a significant decision needed to be made about the care provided. An example of this was the registered manager liaising with a person's relatives when it was necessary for bed rails to be fitted to reduce the risk of the person rolling onto the floor. A person said, "The staff do what's right for me and they ask me what I want and don't just do stuff because they think it' right."
• People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. For each person to whom this applied the registered manager had contacted the appropriate supervisory body. They had also ensured that any conditions of authorisations were met. This had been done to obtain the authorisation necessary to ensure that people only received care that respected their legal rights.

Adapting service, design, decoration to meet people's needs.
• The accommodation was designed and adapted to meet people's needs and expectations.
• There was enough communal space and each person had their own bedroom.

• The accommodation was light and airy most of it was presented to a normal domestic standard. However, there were some shortfalls that detracted from the homely atmosphere. In a communal bathroom the towel rail was badly rusted and the control valves were missing. We raised this matter with the chief executive officer who assured us that the towel rail would immediately be replaced.

• Although all of the windows were fitted with safety latches, seventeen of these latches did not comply fully with national guidance. It is important that suitable latches are in place so that windows do not open too wide and can be used safely. The maintenance manager had already noted that the latches in question needed to be replaced and we noted that arrangements were underway to have new latches installed. Shortly after our inspection visit the Chief Executive Officer confirmed to us that all of the latches in question had been replaced.

Good

Is the service caring?

Our findings

Caring
Caring – this means we looked for evidence that people were supported and treated with 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:
• People were positive about the care they received. A person said, "The staff are fine with me and they're kind." Another person said, "I get on well with the staff because they're just nice people and we all know each other."
• People had been invited to share information with nurses and care staff about their lives. This included information about their family members, significant events they had experienced and their hopes for the future. Nurses and care staff used this information to engage people in conversations about the care they wanted to receive.

Respecting and promoting people's privacy, dignity and independence:
• People's privacy, dignity and independence were respected and promoted. Care staff recognised the importance of not intruding into people's private space.
• Communal bathrooms and toilets had working locks on the doors.
• People could use their bedroom in private whenever they wished. Nurses and care staff knocked and waited for permission before going into bedrooms. A person said, "The staff don't just barge in when they like. They knock and I say that they can come in. That's right because my bedroom is my own kingdom. I don't have a house any longer and so my bedroom is important to me."
• Most bedroom doors did not have locks and so people were not able to secure their private space. We raised this oversight with the chief executive officer. They told us that people had been asked before moving into the service if they wanted to have a lock fitted to their bedroom door. They assured us that people who did not have locks would be asked again. They also said that suitable locks would be fitted as soon as possible if people had changed their mind and chose to have them. We asked four people who did not have locks on their bedroom doors about this matter. None of them wanted to lock fitted. One person said, "I like my door open so I can see staff walking by. If I change my mind I've only got to ask and they'll put one on for me."
• Nurses and care staff discreetly assisted people to use everyday objects in the right way. An example of this was an occasion when a person who lived with dementia attempted to use a cup that had just been used by the person sitting next to them at lunchtime. A member of care staff quietly suggested that they fetch the person a clean cup which they then did.
• Nurses and care staff were consistently courteous, polite and helpful. They addressed people using their chosen names. They gave each person the time they needed to express themselves. Nurses and care staff also checked that they had correctly understood what a person had wanted to say. A person said. "The staff don't rush me along. They take time to sit and chat and I like that."

Supporting people to express their views and be involved in making decisions about their care:
• People had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. An example of this was a member of care staff quietly asking a person if they wanted to be accompanied to go out into the service's garden. When they declined due to there being a slight breeze the care staff chatted with them about going out in the garden another day when the weather was more favourable.
• Most people had family, friends or solicitors who could support them to express their preferences. One person did not have these contacts and the registered manager had arranged for a lay advocate to visit them. Lay advocates are people who are independent of the service and who can support people to weigh up information, make decisions and communicate their wishes.
• Private information was kept confidential. Nurses and care staff had been provided with training and guidance about the importance of managing confidential information in the right way. They asked to see our inspector's identification badge before disclosing sensitive information to us.
• Nurses and care staff only discussed people's individual care needs in a discreet way that was unlikely to be overheard by anyone else.
• Written records that contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff. Nurses and care staff knew about the importance of not using public social media platforms when speaking about their work. A person said, "The staff don't gossip among themselves. If they do need to discuss things I've seen them go into the office to do it."

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Nurses and care staff had consulted with each person, their relatives and healthcare professionals about the care to be provided and had recorded the results in an individual care plan. The care plans were being regularly reviewed by nurses and care staff so they accurately reflected people's changing needs and wishes.

• People told us that nurses and care staff provided them with all the assistance they needed as described in their care plan. A person said, "The nurses keep an eye on my knee for me because it's gets a bit stiff and they help me exercise it." Another person said, "The care staff help me have a bath and they can wash difficult-to-reach places for me."
• People received personalised care that was responsive to their needs including their right to have information presented to them in an accessible manner. When necessary, nurses and care staff quietly repeated explanations they had given to a person about their care. If it appeared a person had not understood what had been said, nurses and care staff used other means to engage a person's interests. An example of this was a member of care staff who thought that a person who lived with dementia might appreciate being assisted to go to the toilet. The care staff discreetly pointed towards the door of a nearby toilet after which the person was pleased to be assisted to leave the lounge to use the toilet.
• People spent their day as they wished. They were free to relax in their bedroom whenever they wanted. A person said, "There's no set routines here as such. I decide what time I get up and go to bed. The staff aren't forever hustling me around."
• People were also supported to pursue their hobbies and interests. There was an activities coordinator present in the service on six days each week. They invited people to participate in small group activities such as gentle exercises, baking and crafts. The activities coordinators also provided people with individual support to enjoy activities such as reading the newspaper, puzzles and nail care. In addition to this, there were entertainers who called to the service to play music and to support people to enjoy singing.
• Nurses and care staff recognised the need to provide care that promoted equality and diversity. They had received training and guidance in respecting the choices people made about their identities and lifestyles. This included people who were lesbian, gay, bisexual, transgender and intersex.

People's concerns and complaints:
• People and their relatives had been given a copy of the service's complaints procedure. The procedure presented information in an easy-to-read way and reassured people about their right to make a complaint. It also explained how complaints would be investigated. A person said, "If there was something not right I know that the manager would do her best to get it sorted out for me. So far though there's been nothing."
• Nurses and care staff recognised that some people who lived with dementia might not be able to speak about any concerns they may have. Consequently, nurses and care staff looked out for indirect signs that a person was dissatisfied with their care. These signs included a person declining to accept support or

becoming anxious during its delivery. Nurses and care staff said that when this occurred they discussed the matter with the registered manager so that any necessary further enquiries could be made.
• The chief executive officer had a procedure to guide them when investigating and responding to complaints. We saw that the chief executive officer had complied with this procedure when managing the small number of complaints they had received since our inspection in October 2016. In each case, they had acknowledged to the complainant their receipt of the complaint. They had established what had gone wrong and what practical steps had been taken to address any shortfalls. An example of this was double checking that people's clothes were discreetly marked with their name. This was in response to a complaint being received about a person's garments being mislaid in the service's laundry.
• We saw that the chief executive officer had notified complainants in writing about the steps they proposed to take to resolve their complaint. In addition to this, the chief executive officer told us that no complaint would be considered as closed until the complainant was satisfied with the conclusions reached and solutions offered.

End of life care and support:
• Suitable arrangements had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.
• Nurses and care staff had consulted with people and their relatives to establish how best to support a person when they approached the end of their life. This included clarifying each person's wishes about the medical care they wanted to receive.
• Arrangements had been made to enable the service to hold 'anticipatory medicines'. This was so the medicines were available for nurses to quickly dispense in line with a doctor's instructions if a person needed pain relief.

Good

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.

Good: The service was consistently managed and well-led. Leaders and the culture they created had promoted high-quality, person centred care.

Continuous learning and improving care:
• The registered manager was completing regular quality checks to monitor and evaluate the running of the service. These checks included the provision already described in this report concerning the management of medicines, learning lessons from incidents and health and safety. When shortfalls had been noted practical steps had quickly been taken to put things right. This included the improvements being made to the service's fire safety system, the fitting of window safety latches, infection control and the installation of bedroom door locks.
• The registered manager also regularly audited each person's care records to make sure they were consistently receiving the support they needed.
• The registered manager and chief executive officer completed unannounced inspections of the service at night time. These were done to make sure that nurses and care staff were completing their duties in the right way so that people reliably received all the care they needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• Care staff were supported to understand their responsibilities to meet regulatory requirements. They had been provided with written policies and procedures to help them to deliver safe care and treatment. Nurses and care staff were told about updated advice from the Department of Health about the correct use of use of equipment, medical devices and medicines.
• There was a senior member of staff on call during out of office hours to give advice and assistance to care staff.
• Nurses and care staff had been invited to attend regular staff meetings to further develop their ability to work together as a team. Records showed that at recent meetings they had discussed important subjects such as the need to keep accurate and comprehensive records of the care they were providing for each person.
• Nurses and care staff said there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. Care staff were confident they could speak to the registered manager or chief executive officer if they had any concerns about people not receiving safe care. They also knew how to contact external bodies such as the local safeguarding authority and the Care Quality Commission.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People had been invited to comment on their experience of living in the service. There were regular

meetings at which people living in the service had been supported to suggest improvements to the service. A person said, "It's okay here for me. It's pretty free and easy and if I have a suggestion to make that's fine with the staff."
• Relatives, staff and visiting professionals had also been invited to complete questionnaires to give feedback.
• Suggested improvements had been acted upon. An example of this was action being taken after people living in the service expressed concern about nurses and care staff sometimes speaking to each other in their first language that was not English. The chief executive officer said and nurses and care staff confirmed that they had been reminded to only speak in English when on duty.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• The registered manager and chief executive officer had established a culture in the service that recognised the importance of providing people with person-centred care. A person said, "I think that the staff get along well with each other and it makes for a happier place. I thought a nursing home would be gloomy but it's not like that at all."
• The registered manager and chief executive officer understood the duty of candour requirement to be honest with people and their representatives when things had not gone well. They had consulted guidance published by the Care Quality Commission. There was a system to identify incidents to which the duty of candour applied so that people with an interest in the service and outside bodies could reliably be given the information they needed.
• It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered manager had conspicuously displayed their rating both in the service and on their website.
• Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is so that we can check that appropriate action has been taken. The registered manager had submitted notifications to Care Quality Commission in an appropriate and timely manner in line with our guidelines.

Working in partnership with others:
• The service worked in partnership with other agencies to enable people to receive 'joined-up' care. The registered manager subscribed to a number of professional publications relating to best practice initiatives in supporting people who need support to maintain their mental health.
• An example of this was the registered manager knowing about important changes being made to the strengthen the provision made to ensure people only receive care that is lawful and the least restrictive possible. This had enabled the registered manager to anticipate the changes and ensure that the service was ready to implement them.