Newgrange of Cheshunt Limited

Newgrange Residential Home

Inspection report

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05 July 2019

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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:
Newgrange Residential Home accommodates 38 people in one purpose-built building spread across two floors. Each of which has separate adapted facilities and communal areas. At the time of the inspection, 17 people were living in the home and receiving the regulated activity of personal care.

People's experience of using this service:

Incidents that occurred in the home were not always managed to keep people safe. Staff awareness of keeping people safe from harm varied and was not consistent.
Training in key areas had not been effectively provided for all staff, however people told us staff were competent and staff felt well supported. People's consent had not always been sought in line with the legal requirements.

People lived in a purpose-built home that although newly refurbished did not meet the needs of people living there. Particularly people living with dementia. The environment was well maintained, and appropriate safety checks were regularly completed.

Quality assurance audits were not always effective in identifying people's experience of the service. Care records were not reflective of people likes, dislikes, preferences and changing care needs, or care that had been provided and required monitoring.

People told us they felt safe. One person said, People told us they felt safe. One person said, "Absolutely I feel safe, it's a very nice home with kind staff." People were supported by sufficient numbers of staff. Staff recruitment checks were in place. Staff were clear about how to respond in an emergency such as a fire. Risks to people safety and welfare were identified and responded to promptly by staff. People were cared for in a clean and hygienic environment by staff who followed infection control procedures.

People, their relatives and staff told us that the quality of care received was sufficient and they were happy with the care provided. People's dignity was maintained and people's independence was promoted and respected.

People were happy with the food provided and meal times were a sociable event. People's weight and dietary needs were monitored where necessary.

People told us their care was responsive and tailored to their preferences, although care records did not reflect this. People were able to take part in a wide range of activities and outings. People and their families were involved in their own care planning as much as was possible.

People and relatives felt able to raise complaints and an effective complaints procedure was in place.

Staff felt well supported by the registered manager. People and relatives were able to raise suggestions about the management of the service.

Rating at last inspection: Good (report published 01 December 2016)

Why we inspected: This was a planned comprehensive inspection based upon the previous Good rating. At this inspection we found that the service is now rated as Requires Improvement. More information is in the full report.

Follow up: We have referred our findings to the local authority. We will continue to monitor all information received about the service to understand any risks that may arise and to ensure the next inspection is scheduled accordingly.

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? 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**

Newgrange Residential 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 team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type:
Newgrange Care Home 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. We visited Newgrange Care Home on 26 June 2019 and on 05 July 2019.

What we did before the inspection:
We reviewed information that we held about the service such as statutory notifications. These are events that happen in the service that the provider is required to tell us about. We reviewed the last inspection report and information that had been sent to us by other agencies. We contacted commissioners who had a contract with the service, and the local authority safeguarding team. We used this information to plan our

inspection.

During this inspection:
We spoke with seven people living at Newgrange Care Home and three people's relatives.
Nine members of staff including the chef along with the registered manager, deputy manager and provider.
We spoke with two visiting professionals.

We reviewed five people's care records to ensure they were reflective of their care needs including records of incidents and accidents that occurred.
Documents relating to how staff were supported such as training records and minutes of meetings.
Documents relating to the management of the service such as policies, audits, and safeguarding records.

After the inspection:
The provider sent information that we requested including training records, actions taken as a result of feedback and their service improvement plan. We took this into account when making the judgements in our report.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection the rating has deteriorated to Requires Improvement.

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
●Risk to people`s health and well-being were assessed, and in most care plans reviewed, assessments were in place to detail how to mitigate those risks.
●We found though that measures in place were generalised and not specific to each person's individual needs. For example, for each person identified at risk of developing pressure ulcers their care plan said, "All skin bundles or skin assessments to be updated monthly or as required. Any changes in skin integrity to be reported to senior in charge. Staff to ensure that all changes are fully documented in care notes if there is blanching, a wound or moisture lesion, this need to be photographed with consent and a full wound care plan commenced. Person to be assessed for pressure relieving devises when needed. Staff to be aware of the psychological care of person and offer reassurance and understanding." This did not address the specific and preventative measures required to proactively manage people's identified risk of developing pressure wounds.
●Staff were knowledgeable about risks and they knew people very well. Staff were aware of those at risk of falls, pressure ulcers, weight loss, and who had their food and fluid intake monitored. However, mobility care plans were not always in place for staff to know how to mitigate the risks involved when supporting a person to mobilise. These had been developed at our request by the time we returned to the home the second day of the inspection.
●People who were at risk of constipation did not consistently have this risk supported. Staff recorded if people had a bowel movement and they administered prescribed laxatives for people. Staff did not however review records regularly to ensure that people had regular bowel movements.
●Positive behaviour support plans were not in place for people who experienced episodes of depression, hallucination and anxiety. A person`s care plan detailed that they had a diagnosis of depression, paranoia and experienced visual hallucinations. The care plan was not detailed enough to describe how staff should support the person effectively to prevent or cope with these issues effectively.
● Regular assessments were carried out on fire and water systems. All staff were aware of the evacuation plans that were in place in the event of needing to leave the building in an emergency such as a fire. Regular drills were carried out. One person confirmed this and said, "They set the alarm of every so often and show us where we should go and stand." All staff had received training, and those spoken with confident in dealing with an emergency in a safe and controlled manner.

Systems and processes to keep people safe from harm; Learning lessons when things go wrong:
●We found that not all the unexplained injuries people sustained were reported and registered on the

appropriate log. For example, staff completed a body map for a person, recording they had applied a dressing on the person`s left arm because they discovered small skin tears. We confirmed there was no incident report completed, or explanation given as to how these were sustained.
●We found one person managed to leave the home without staff`s knowledge and was later found by the police. This had not been reported to local safeguarding authorities or CQC as required.
●People told us they felt safe. One person said, "Absolutely I feel safe, it's a very nice home with kind staff."
●Staff were knowledgeable about safeguarding procedures and how to keep people safe. Staff said they recorded any injuries, bruises they noticed on body maps and reported these to their managers. Information relating to keeping people safe was visibly displayed at the home to prompt people, visitors and staff to report any concerns they may have.
●Staff told us that any lessons learned from accidents and incidents were discussed in handovers, staff meetings and supervisions if there were any lessons to be learned, however this was not an agenda item in staff meetings.

Using medicines safely
● People received their medicines when needed.
● In most examples reviewed, records tallied with stock held. However, one person's medicines remained in the controlled medicines cupboard after staff had recorded this had been returned to the pharmacy. The person no longer required this medicine, so this was a recording issue. This was remedied when we visited on the second day.
● There were regular checks on medicines management within the home and any shortfalls were addressed straight away.
● Staff had received training and staff competency was regularly reviewed.

Staffing and recruitment
●There were enough staff on duty on both days of the inspection. The home was calm, staff were seen to be able to spend time with people and were not rushed. People told us there were enough staff. One person said, "I feel safe because the care is good, it's well run, medication on time, and basically there is 24hr care, that makes me feel very safe."
●Staff told us they were enough staff to meet people`s needs. One staff member said, "Every day is different but usually is ok with staffing."
●The registered manager reviewed staffing levels, and would adjust them according to people's changing needs.
●People only worked at the service once references had been sought and verified and criminal background checks were completed. Once staff were offered a position they underwent an induction, shadowed staff and worked with people when assessed as competent.

Preventing and controlling infection
●All areas of the home were clean and freshly decorated. Regulars checks and audits were undertaken and sufficient numbers of domestic staff were employed to keep the home clean.
●Staff were seen washing their hands and wearing protective equipment like aprons and gloves when supporting people. One person said, "Staff always wear gloves and aprons, they never fail."

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience:
- Staff told us they received training to develop and further their skills and knowledge. Staff told us they received training in safeguarding, health and safety, dementia, infection control and other areas considered mandatory by the provider.
- Some staff told us they were Champions in their area of interest. For example, one staff member was a dementia champion and they told us their role was, "To give support and advice to staff on how to deal with difficult situations. Raise awareness about how people with dementia feel to staff and families."
- However, staff had not always received training to understand how some health condition like Parkinson impacted on people's daily living, mobility, behaviour and other areas. Staff told us when they had dementia training they discussed Parkinson in part of the training but not in-depth. On the second day of our inspection the registered manager had reviewed their planned training. This had training booked in areas such as end of life care, continence, nutrition, pressure care and diabetes.
- Staff told us, managers were supportive, and their doors were always open. One staff member said, "Managers are approachable and very easy to talk to."
- Staff told us they had regular supervisions where they could discuss in-depth their development needs. One staff member said supervisions were, "Used to discuss if we are happy, any issues, policies and procedures and training."

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.
- People had their capacity assessed for relevant decisions, and best interest decisions were recorded

appropriately. However, we found the principals of the MCA 2005 were not consistently met.
●For example, one person was identified of not being able to maintain a healthy weight. The person's GP was involved in their care, however this was not investigated further because the person's relative's decided it wasn`t in the person`s best interest. Staff could not tell us if the relatives had the legal power to make this decision on the first day of the inspection.
●When we returned to the service staff told us they arranged a GP visit to discuss what was in the person`s best interest as the relatives had no legal power to solely take the decision of not investigating health issues. The registered manager had identified the need to increase awareness for managers and staff and review the consent arrangements in place.
●We saw, and staff confirmed that they used bedrails for a person to keep them safe. There were no risk assessments, MCA or best interest decision in place to evidence that this was the least restrictive method to keep the person safe. We provided this feedback to the registered manager, and when we visited on the second day this had been updated and assessments were in place.
●DoLs applications had been made and people were being supported in the least restrictive way while these were awaiting authorisation. For example, people had regular opportunities to go out.

Supporting people to eat and drink enough to maintain a balanced diet
●People told us they enjoyed the food, and were provided with a choice of meals, snacks and drinks. One person said, "I thought the food was very good, I heard people asking for other options and the girls just took it in their stride and said ok not a problem I will go and ask the cook."
●Food looked appetising and choices were available. Tables were laid out with cutlery, glasses and condiments, and the mealtime was sociable. Those who required assistance with eating were supported appropriately.
●However, a number of people living in the home had continence needs and were prescribed medicines to alleviate this. The chef told us they were not involved in reviews of people's care, and that they could support people's continence through diet if they were informed. On the second day of the inspection, the chef had access to people's care records, and was scheduled to undertake nutrition champion training to enable them to support people's nutritional needs.
●Some people were assessed as needing staff to monitor their food and fluid intake. One person's fluid was required to be restricted to a maximum daily amount. This was closely monitored and although the amount was not totalled, when we checked they didn't exceed the maximum recommended amount. The registered manager reviewed this and redesigned the food and fluid form to ensure daily amounts were reviewed.
●For other people there were no guidelines on a recommended amount for them to drink. The total amounts of fluid consumed were not documented.. Recommendations for staff to know when they had to report a person was not drinking sufficient amount were not in place. We asked a staff member when they would report concerns about a person and they said, "If [person] is taking enough then we would not report. 1000ml is acceptable but 500ml is low. We were not told how much people should be drinking we are just documenting."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had their needs assessed prior to moving into the service to ensure their needs could be met by staff. Any plans and equipment required was in place when people arrived. Care plans were then further developed as staff became familiar with people's needs, choices and preferences.
●Assessments of people's needs were carried out in partnership with professionals, such as GP's, mental health teams, hospital social workers or district nurses. This helped to ensure the service developed a plan of care that reflected best practise.
● Staff were kept informed of expected standards of care and supported by the management team.

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

●The environment was newly decorated to a high standard; however, this did not meet the recommended best practice guidelines issued by SCIE and NICE for a supportive environment for people living with Dementia.

●Staff told us the majority of people living in the home had dementia, however there was very little colour contrast used on corridors, hand rails, bedroom doors and toilets/bathrooms for people to find orientation easier. People had their names on bedroom doors, however no memorabilia was used to prompt people to recognise their bedroom easier. Rummage baskets or any other items to trigger reminiscing and occupy people were not visible.

●There were no door codes or locks on the doors inside the home. This included free access to stairs. This could potentially present a risk for people living with dementia who like to walk around. People`s care plans had no risk assessments to detail if anyone was at risk of falling on the stairs or if the risk of having free access presented any risks for people.

●The building had been designed in a way that allowed people to move around freely.

● There was an accessible garden which we saw in use and quiet areas if people wanted to be alone with visitors.

● Bedrooms were personalised, and bathrooms were welcoming.

Supporting people to live healthier lives, access healthcare services and support

● People had regular access to health and social care professionals. One person said, "You only have to say you're not well, or can you see a doctor, and they are straight on to it, I have had the optician in here and got new glasses, the chiropodist comes regularly, there is everything on hand."

● We saw that people were visited by the optician and chiropodist and as needed referrals were made to specialist healthcare teams, such as the tissue viability nurse or the speech and language team. The GP held regular clinics and people were supported to attend health related appointments in the community.

Good

Is the service caring?

Our findings

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

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

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

- People told us that staff were kind and respectful. One person said, "We are just like a big family here, they [staff] are always busy but because there aren't that many of us really, we all get a bit of attention, they do their very best, they are kind and gentle when they come to wash me, they do things at my pace, no hurrying, always knock before entering and talk to me whilst they are washing me we have some really lovely chats."
- Interactions observed between staff and people were positive. We saw staff being attentive and reassuring to people. One person was distressed, and a staff member spent time with them chatting and used a soft, gentle tone whilst sincerely reassuring them.

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

- People and their relatives were involved in planning and reviewing their care. One person said, "They are very nice, very respectful, I am a person that likes my own company, they always make an effort to speak to me and make me feel part of the home. I get help with a wash and shower, they always take their time with me, and listen to me. I should say my care is exactly how I want it." Relatives told us that staff contacted them about any changes if appropriate.
- Care plans recorded people's involvement and their views and opinions about their care.
- Staff asked people before supporting them. For example, staff asked discreetly if they required help with personal care. Staff would ask people if they could transfer them in their wheelchair and asked people to lift their feet to put the footplates down. We saw throughout the day that staff did not make assumptions but sought people's views.

Respecting and promoting people's privacy, dignity and independence

- Staff knocked on doors to people's rooms before entering. One person said, "They give me my own space and respect that. I know they need to check on me, but they will always knock before coming in, and tell me who is visiting."
- People said staff respected their dignity, particularly when providing personal care. One person said, "Being washed by someone is a difficult thing, but they have never made me feel awkward or embarrassed. They are very sensitive to me, they understand it's difficult for people to have done and always treat me kindly."
- People told us they were able to have visitors when they wanted, and there were places in the home they could see their visitors in privacy.
- People said staff promoted their independence and staff were able to discuss examples of where they did so while supporting them with personal care. One person said, "I like to wash as much as I can, and they do

that. Staff will do anything we want, but they do like us to manage the bits we can."

● People who had difficulty communicating were listened to in a dignified and respectful manner. Staff knelt by the person, ensured they had eye contact and spoke clearly when talking with them. Staff ensured people's glasses were clean, and hearing aids were in place.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection the rating has remained 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

- People told us that they were happy with the care they received, and it was delivered in a way they preferred. One person said, "I am happy with things, very much so. When it was closed I wasn't happy where I was but being back is wonderful." A second person said, "Everything is how I want it from when I get up to when I go to bed. I choose how I spend my day, with who I want to. I know some of these staff so well it's like having care given by my family."
- People told us care was delivered in accordance with their needs and preferences. Care plans were in place and identified what people's needs were and what actions were needed to meet those. Care plans lacked personalisation and the care people received was not always reflected in the care plans. However, staff awareness of people's needs, choices and preferences meant a lack of recording did not affect outcomes for people, who still received personalised care.
- Staff told us they knew people well and they provided personalised care to people. They knew when people liked to get up, go to bed and what their food likes, and dislikes were. We confirmed this with people and their relatives. However, this was not reflected in the care plans.
- Care plans included clear information so that care could be delivered safely and appropriately. There were handover records used which gave staff a clear overview of people's needs, and any updates needed. For example, if a person needed to be encouraged to drink more or if someone felt unwell.
- People and their relatives told us that staff were very responsive to any concerns or worries about a person's welfare.

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.

- Staff took time to communicate with people who had limited or no communication skills. Staff told us they looked at how people grimaced, or how they held themselves in a particular way for possible signs that the person was in pain. Pain scales were used as guidance to help staff check for any discomfort or distress.
- Staff knew how each person needed to be supported with communication. Staff understood people's abilities well and how they needed to approach people. For example, if people were hard of hearing or who had impaired vision. We saw staff working in a way that aided people's communication.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●People told us there was a range of activities and social interaction in the home. One person said, "I love the activities, I am never bored."
●There were activities going on during the inspection, all of which followed a weekly planner that changed regularly following people's feedback. On the day of the inspection, activity staff were on leave. Staff had rallied round to put on activities for the residents. These were chair exercises, arts and crafts, and people singing along to golden oldies with the staff. People were smiling and engaged throughout.
●Staff had sought different ways to provide meaningful and stimulating activity. Recently, the home had organised an event for people that transported them back to the 1950's to 1970's. People told us they enjoyed this event which also supported people living with dementia to recall memories from their past. People also planted their own flower seeds and plants for the outside area of the home, where visitors were encouraged to visit whilst enjoying an opera singer and barbecue.
●Staff took time learning about what people enjoyed but were also aware of those people who were not as sociable. One person said, "I don't do most of the activities, I like the exercises I join in sometimes, and like to listen to the musical entertainment, otherwise I'm not a big mixer, I'm happy enough sat here, I don't feel like there are any restrictions here, it's very easy going." Staff were attentive to this person throughout the day, popping into their room to ensure they were not lonely or feeling isolated.

Improving care quality in response to complaints or concerns
●People and relatives told us they had no complaints but felt confident to raise an issue if one arose. One person said, "[Registered manager] is only along the corridor, if I wasn't happy then I would speak to them and they would get it fixed." A second person said, "If I had any complaints or If I had a concern I would approach them [Managers], even the girls that look after us, I could tell them anything, I wouldn't be afraid to do so."
●Complaints recorded were logged to enable monitoring of their progress.

End of life care and support
●At times, end of life care was provided at the service. The team worked with the local hospice to ensure they had up to date knowledge and people were supported in a dignified and pain freeway.
●Care plans were developed alongside the GP and visiting professionals when a person was nearing the end of their life.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection the rating has deteriorated to Requires Improvement. This meant that service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care

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

●People's care records were not comprehensive and did not describe specifically how to provide care to people. For example, the 'All about me' document where people recorded what their likes, dislikes and preferences were. This told staff they would like a daily shower and a shave every day. This was not reflected in the care plan for personal care.

● Not all staff used the electronic care planning system effectively. The care plan was structured so that for each identified need staff could record what the desired outcome was by meeting those needs. Staff were noted to be recording actions under the outcome section and updates. For example, GP visits were not under the relevant section. This meant when information was needed about a person health needs this was difficult to find resulting in the whole care plan being reviewed. This presented a risk that important information not recorded in the right section may be missed.

● People and their relatives told us they thought the service was well organised and managed and relatives were positive about the management team. One person said, "You could go to any of them [Managers] with anything, they would sort it, they are lovely people."

●Staff were very positive about the registered manager. One staff member said, "[Registered manager] is brilliant, I've not been here long but they are someone I look up to. They are so helpful and passionate about this home."

●Staff told us that they felt supported in their role and that the registered manager and provider were visible and supportive.

● The registered manager worked well with the deputy manager to ensure that people received care in a person-centred way. They gave guidance to staff and explained the importance of it. One staff member said, "Staff are so different now, they really care about the place and are keen to learn." We saw that meetings notes recorded that the registered manager had invited staff to realise this was also their home and they should be proud of it.

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 management team took their responsibility seriously. Staff told us that they were friendly but also advised if they were not working in a way that was expected. One staff member said, "They tell me if I'm doing something wrong, in a nice way but they make sure I know."

● We noted that most reportable events were reported to the appropriate body.

Continuous learning and improving care

●Incidents were identified and noted by staff, however these were not always recorded in the correct place, meaning the registered manager was not made aware of all incidents. For example, staff had recorded on a body map an incident regarding one person who became anxious and agitated. This had not been reported to the registered manager, along with an additional two incidents resulting in a bruise and skin tear for a second person. Although staff took appropriate actions to manage the incident and referred appropriately to the GP or relevant health professional, the registered manager was unable to effectively monitor the home as they did not have the full information. Subsequent to the inspection they reviewed their reporting and monitoring of incidents to ensure they maintained a greater oversight.

●Staff told us that they discussed among themselves when things went wrong, on a day to basis, but did not formally share the analysis of falls, incidents, complaints etc. in team meetings. Staff said they were aware of individual incidents, or where practise could be reviewed, but not as a whole team. One staff member said, "Lessons learned are not in team meetings, we review when [Person] falls, but we don't think about what we could have done differently."

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

● The management team carried out checks and audits to satisfy themselves that standards were adhered, and regulations were met. Where these checks had identified shortfalls, action plans were implemented to address those areas. However, we identified further areas where these audit tools had not been effective in addressing areas for improvement. For example, with monitoring consent, medicines auditing, accurate recording in relation to people's care and training and development.

●Although when we returned on the second day of inspection the registered manager had developed a robust action plan to address these areas, their systems had not identified them prior to our visit.

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

● People, their relatives and staff were invited to take part in a survey. The results from this survey were being analysed and would be shared. People and relatives told us there were regular opportunities for meetings. One person told us, "Meetings happen, it's a chance for us to say what we think and what we want. Food is always a hot topic." People also told us that managers regularly walked around checking that people were okay and happy. People told us management were responsive to any suggestions made within those forums.

● Staff told us there were regular meetings and opportunities to speak with a member of the management team. One staff member said, "We have them every couple of months. I was able to bring up an issue about holidays, where my week before was Sunday to Saturday and I didn't understand how it worked here. The manager explained it to me and I was happy with that." We spoke with the provider and registered manager about how they could use team meetings to review incidents, patterns and themes emerging to enable a wider awareness of the key issues. They agreed to develop their agenda for meetings to incorporate these areas.

●There was a registered manager in post who was supported by the provider. The registered manager was aware of the requirement to notify the CQC of certain incidents, however our findings showed that these notifications were not consistently sent in as required.

● The registered manager and staff team had developed strong links with the local community. For example, they had taken part in a dementia awareness week, organising activities in the home and inviting the local community to visit and support their initiative.

Working in partnership with others

●The management team worked with the local authority and clinical commissioning group when required. They also worked with a local hospice to extend knowledge and continuously develop end of life care provided to people.

●There was a Business Continuity Plan in place which covered a number of eventualities such as loss of premises or moving people. This plan incorporates a range of community businesses and community links to ensure a safe and efficient deployment if needed.