Amesbury Abbey Limited

Winton Care Home

Inspection report

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Date of inspection visit:
17 August 2021
23 August 2021

Date of publication:
29 September 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Winton Care Home is a care home providing personal and nursing care to up to 39 people including those living with dementia. There were 28 people using the service when we inspected. The property is a grade 2 listed building. The accommodation is arranged into two main areas. The main house is the older part of the building and dates back to the 18th century. The newer wing was built in 2000 and was purpose built to be care home accommodation. Both wings have three storeys. The premises are located within extensive parkland.

People's experience of using this service and what we found
There were not always enough staff available to be fully responsive to people's needs. Risks to people's health and wellbeing had not always been managed safely. Medicines were not always managed safely. Action was needed to address some environmental risks. As part of CQC's response to the coronavirus pandemic we conducted a review of infection prevention and control (IPC) measures in the home and found that some improvements were needed. There were systems and processes in place to safeguard people from the risk of abuse and to learn from safety related events.

This inspection found that the governance arrangements in place were not yet being fully effective at identifying all of the areas where improvements were needed. This inspection identified a number of areas where the quality and safety of the care provided had been compromised. Records were not always up to date or reflective of people's needs and did not provide assurances that care was always being delivered as planned.

The manager had been in post for three months when we inspected. They had begun to identify areas where improvements were needed and had an action plan in place to meet these. The manager maintained a visible presence within the home and actively supported staff and interacted with people on a daily basis. Staff were clear about their role and responsibilities and spoke positively about the managers leadership and their impact on the service since their appointment.

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

Rating at last inspection
The last rating for this service was 'good' (published February 2018).

Why we inspected
The inspection was prompted in part due to concerns we had received about medicines management and staffing levels within the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

We reviewed all the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to requires improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified new breaches in relation to safe care and treatment, staffing, fit and proper person's employed and good governance.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Winton 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two inspectors, a pharmacist specialist 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 care service.

Service and service type
This service 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 did not have a manager registered with the Care Quality Commission. The current manager had been appointed in May 2021 and had submitted an application to register with the Commission. If registered, this will mean that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. We sought feedback from health and social care professionals. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
Some people were not able to fully share with us their experiences of using the service. Therefore, we spent time observing interactions between people and the staff supporting them in communal areas. We spoke with five people who used the service and seven relatives. We also spoke with the manager, head housekeeper, a registered nurse, a health care assistant and the laundry assistant.

We reviewed five people's care plans in detail and a further nine people's charts and others documentation. 18 medicines administration records, four staff files and a variety of other records relating to the management of the service were also viewed.

After the inspection
We spoke with five care workers and received written feedback from a further 12 staff across a variety of roles. Four health and social care professionals provided feedback about the service. We also continued to seek clarification from the provider to validate evidence found.

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

Assessing risk, safety monitoring and management;

- People and their relatives told us the service provided safe care. One relative said, "I feel [person] is entirely safe at Winton, we have no concerns" and another said, "No concerns, it's a great comfort, I feel she is very well looked after".
- However, we found a number of examples where we could not be assured that risks to people's health and wellbeing had been adequately managed.
- We viewed in excess of ten people's fluids charts. These did not provide assurances that people at increased risk of dehydration were always being offered regular drinks. We viewed a number of fluid charts with the manager and were not assured that drinks were always being offered outside of mealtimes or drinks rounds. On the second day of our inspection, one person's fluid chart showed that at 4pm, they had only been offered drinks twice during the day. They had drank just 5mls of fluid. The manager and the inspector visited another person whose mouth looked dry. The manager arranged for a staff member to offer these people a drink straight away.
- One person lived with epilepsy, but they did not have a seizure plan which provided staff with information about the nature and frequency of the seizures or what response should be made if the person had a seizure. The GP has been asked to review this.
- One person had been living at Winton Care Home for six weeks, but staff had not completed a comprehensive assessment of their needs or identified how these should be met.
- One person was living with diabetes. There was a lack of clarity regarding how often staff should be checking the person's blood glucose levels. Their care plan said this should be completed randomly, the handover sheet said it should be done weekly. The last record of a blood glucose reading was on the 2 July 2021. The registered nurse we spoke with told us it was their understanding that this should be completed weekly. We found the same concern in relation to another two people's blood monitoring records. The manager has liaised with the GP to review the diabetic care for these people.
- One person did not have a suitable diabetic care plan which contained all of the information required to support staff to manage the risks associated with this health care need. For example, the person was more prone to high blood glucose levels, hyperglycaemia, but their care plan only made reference to low blood sugar levels, hypoglycaemia.
- Records did not provide assurances that people had received continuity of wound care which increased their risk of developing skin damage. For example, one person's wound care management plan said the next review was due on the 7 May 2021. We could find no further records relating to this. We saw another similar example.
- Turning charts indicated that people were not always being repositioned in line with their risk assessment. Staff told us they did not always have time to do this.

● We reviewed the repositioning charts of two people for a seven-day period. These also showed periods where their skin care had not been provided as planned. At the end of this period, both these people were noted to have developed some degree of skin damage.
● Records did not provide assurances that people at high risk of skin damage always had barrier or topical creams applied as prescribed.
● In July 2021, there had been an incident whereby a person had developed skin damage. The investigation had shown failings in the way in which staff had monitored this person's skin and communicated concerns. We were not assured that the learning from this incident had been embedded.
● Whilst people's care plans did contain some detailed and personalised information, they did not always accurately reflect people's known risks or provided conflicting information. One person's choking risk assessment had not been updated following a choking incident. The choking risk assessment assessed the person as low risk of choking and as not requiring any assistance from staff. Other documentation stated staff should monitor the person when eating. In a second case, a person's nutrition plan stated that they needed level one fluids, the handover form stated level two fluids. The person's nutrition plan stated that they required normal fluids. We were concerned that in light of the continued use of agency staff, the lack of accurate or up to date records could present risks to people's wellbeing.
● Food charts indicated that in a small number of instances, staff had provided drinks of the wrong consistency to two people who required their drinks to be thickened due to swallowing or choking problems.
● The design and layout of the building presented some challenges due to its age and design. Overall, there was evidence that the provider undertook regular health and safety checks of the premises and of equipment within it as required in order to ensure that the premises are safe and suitable for the purpose for which they are being used. However, we did note some areas of concern.
● We found that a loft hatch had been removed to help ensure that machinery used to operate the lift did not overheat. This reduced the effectiveness of the fire compartmentation. This has now been replaced.
● We found that an occupied room on the upper floor had a window restrictor which was not tamper proof as required by health and safety guidance.
● The nurse call system only had display panels on the ground floor which meant that staff working on the other floors had to come down to the ground floor to find out the source of the call. We were concerned this could lead to a delay in emergency calls being responded to.
● The railings protecting a staircase, which people had access to, were lower than that recommended by best practice guidance. This increased the risk of falls from height. The provider is taking action to address this.
● There were a number of staircases within the home which were accessible to people, but we were not assured that the risk of people accessing these independently had been adequately risk assessed.
● Safety tests of portable electrical appliances had in many cases lapsed in some cases by in excess of 12 months.

Systems to manage risk were not sufficiently robust. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements were needed to ensure that the design and layout of the premises took account of national best practice to ensure that the physical environment was supportive of people living with dementia, or other sensory deficits and enabled them to safely and meaningfully interact with the environment in which they lived.
● Some of the furniture and furnishings were tired and worn and in need of replacement. This is important to ensure that they do not present a risk to people, for example, worn and rippled carpets that can present a

trip hazard, but also to ensure that good infection control practices can be maintained. There was evidence that the provider was taking action to replace and update furnishings and flooring. They had recently installed a new wet room and kitchenette in the Wing.

● People had personal emergency evacuation plans (PEEPS) and there continued to be a business continuity plan in place which set out the arrangements for dealing with foreseeable emergencies that could affect the running of the home.

Staffing and recruitment

● The people we were able to speak with did raise some concerns regarding staffing levels. One person told us there were, "Not enough staff, have to wait a long time" and another person told us that staffing levels meant they were not always able to have a shower when they wanted one. A third person said staffing was a "Problem".

● Relatives were positive about the staffing levels, comments included, "There is a high ratio of staff…the staff will sit down and chat", "There is always someone around" and "I'm so impressed with the numbers of staff there".

● However, all of the staff we spoke to raised some concerns with us about staffing levels. Some staff felt that staffing levels were sometimes unsafe. For example, one staff member said, "Honestly, it's not safe… last weekend there were just two staff on either side… nine times out of ten there is no one there with those who are wandering".

● Whilst we didn't see anyone waiting for help or assistance, we did see that there were times when staff were not available in the communal areas.

● Two staff members told us how they had to make difficult choices about who to get up in the morning as staffing levels might mean that they were not able to support them back to bed.

● Staff told us, and records confirmed, that they were not always able to reposition people cared for in bed to help prevent skin damage. For example, one staff member told us they had completed an early evening shift. They said, "On [date] there were no activities staff in, so the resident's downstairs were restless, those in bed had had meals and drinks, but no other care since the morning".

● Other staff felt that staffing levels were usually safe but did not allow them to provide care in a person-centred manner or to just spend time with people. Many staff spoke of sometimes only having time to provide basic care rather than the thorough care they wanted to.

● We reviewed the rotas for the three weeks prior to our inspection. These showed that planned staffing levels were not always being met. For example, 40% of early shifts fell below planned levels.

● On two occasions there was only one nurse and one care worker on duty between 6.30pm and 8pm when there should have been one nurse and three care workers. This can be a busy time with some people needed help to retire to bed.

● There were similar challenges on the Wing which is the unit supporting people living with dementia.

● One person had requested additional one to one hours each day. We were advised that this was not for safety reasons, but out of personal choice, however, between 25 July 2021 and 19 August 2021, this one to one care had not been possible to provide on 18 occasions due to staffing challenges. Staff told us that sometimes, even when assigned to the one to one support, they were put in the difficult position of being asked to supervise the lounge at the same time.

● Agency workers were needed most days. Wherever possible, agency staff were block booked to help provide continuity of care, although recently the manager explained that it was proving hard to even secure agency staff.

● There were also shortages of kitchen, domestic and laundry staff.

● The staffing challenges had worsened in July and August 2021 as staff took leave, but most staff said that the home had been short staffed for some months and that it was impacting upon safety, people's care and their own morale. In light of this we were concerned that management had taken the decision to proceed

with seven new admissions to the home since June 2021.

The provider had not ensured that there were always sufficient numbers of staff deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised our concerns about staffing with the manager. The manager told us that they would suspend new admissions to the home whilst they and the provider continue to undertake a range of measures to try and attract new staff.
● Most of the required recruitment checks had been completed. However, we found that in one case, there was no documented risk assessment for a minor disclosure on a Disclosure and Barring Service (DBS) certificate. DBS checks help employers make safer recruitment decisions. We were told that the risks of the disclosure had been considered but not documented.
● No record had been maintained of who had seen another staff members DBS in order to be able to confirm that this did not contain any disclosures that might need further risk assessment. This is important as copies of DBS certificates are no longer routinely kept on files for confidentiality purposes.
● The manager was not able to provide us with profiles for two agency staff who had recently worked in the home. This is important information as it demonstrates to the manager and provider that agency staff are suitably trained and skilled and have had DBS checks.
● The profiles for a further two agency staff showed that they did not have all of the training relevant to their role.

The provider had not ensured that all of the required recruitment checks were being completed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always being managed safely.
● Medicines were not stored within their recommended temperature ranges. Temperatures where medicines were stored were not consistently and appropriately monitored. Staff were not all aware of the recommended temperature ranges for medicines and the records lacked enough detail to guide staff.
● Medicines were not always administered to residents consistently or appropriately.
● There had been seven medicines administration errors in June and July 2021. One of these took place for a period of 12 days before being identified. Appropriate actions were taken once the medicines errors were identified.
● Information to support the safe administration of medicines was not always present in peoples' care plans and medicines administration records (MARs). For example, information about medicines allergies was sometimes absent or inconsistent. Behaviour management plans were either absent or were incomplete. Those that were completed lacked guidance on when the use of medicines would be appropriate or supportive. Information about medicines that required additional monitoring or risk assessment was not always present in people's care plans.
● Administration of variable dose and topical medicines were not recorded consistently. Staff signed MARs after giving a medicine. However, if a variable dose was prescribed, the dose given was not always recorded. Staff did not always record the administration of topical creams, as part of personal care, on the topical medicine administration records. Some, but not all administrations, were alternatively recorded in the daily notes.
● In March 2020 anticipatory medicines for end of life care were authorised by the GP for the majority of people who had been using the service at that time. At the time of the inspection the need for these

medicines had not been reviewed or the authorisation for their use withdrawn.
● Medicines audits were undertaken on a regular basis by the service, but these did not identify the concerns we had identified.
● Three of the four medicines administration records folders were not stored securely.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely.
● Staff had identified some medicines were overstocked. Therefore, they had changed the medicines ordering process and were managing down the quantities of medicines held.
● Staff checked controlled drugs stock regularly in line with national guidance.
● Staff administered people's medicines in a person-centred manner. One relative told us, "Sometimes, [person] has difficulty swallowing it, I have seen the nurse watching her take it, she takes time with her".

Preventing and controlling infection
● As part of CQC's response to the coronavirus pandemic we conducted a review of infection prevention and control (IPC) measures in the home.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● Relatives told us the home was always kept clean and we observed that the cleanliness of the home during the inspection was satisfactory. However, people and staff told us, and records confirmed, that scheduled cleaning tasks did not always take place largely due to the lack of weekend housekeeping staff. This had been a problem since March 2021.
● There were no cleaning schedules for frequently touched areas in line with best practice guidance in response to the Coronavirus pandemic. It has been recommended that these are implemented as soon as possible.
● Whilst some action was being taken to replace or update furniture within the home to ensure that this was easy to keep clean, more still needed to be done.
● We were somewhat assured that the provider was admitting people safely to the service. The circumstances of a recent respite admission had not been managed fully in line with guidance at the time.
● We were assured that the provider was preventing visitors from catching and spreading infections. One relative told us, "I have to have a test every time I visit".
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was making sure infection outbreaks were effectively prevented or managed. Relatives were full of praise for the staff team and how they had responded to a COVID 19 outbreak earlier in 2021. For example, one relative said, "It was staggeringly good how well the carers took care of [person], they couldn't have done more".
● We were assured that the provider's infection prevention and control policy was up to date.

● Systems and processes to safeguard people from the risk of abuse
● Relatives were confident that their family members were safe from abuse.
● The provider had appropriate policies and procedures which ensured staff had clear guidance about what

they must do if they suspected abuse was taking place.
● The manager visited people regularly to check they were happy and felt safe and she encouraged them to raise any concerns they might have.
● Staff were confident that any concerns raised would be acted upon by the manager to ensure people's safety.

Learning lessons when things go wrong
● The manager reviewed incidents and accidents to ensure that mitigating actions were being taken and that any themes or recurring risks were identified allowing further remedial actions to be taken. There was scope to develop this further.
● Root cause analyses had taken place for more significant incidents. These had been completed in a transparent manner and the outcomes shared with staff.

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 this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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 inspection highlighted a number of areas where the safety of people's care had been compromised. These are described further in the safe section of this report.
- Records relating to people's care and treatment were not always complete, accurate and up to date. Staff told us this was because staffing shortfalls meant that they had to focus on trying to meet people's basic needs rather than completing charts, updating care plans and risk assessments. The provider has plans to introduce electronic records once there is appropriate infrastructure in place to support this.
- Shift leaders were not consistently auditing documentation such as turning or fluid charts to ensure that care was being delivered as planned.
- Although clinical risk meetings took place and a good range of audits completed, these had not been fully ineffective as they had either not identified or resolved the issues this inspection found. This was in part due to changes in leadership, the challenges faced by the COVID 19 pandemic and the current staffing shortfalls.

The systems in place were not being effective at ensuring compliance with the fundamental standards. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had identified some of the concerns we found and had plans in place to strengthen governance. Their conversations with us demonstrated that they had a realistic understanding of the challenges facing the service and some improvements were already underway. For example, the manager had been working with the local surgery and pharmacy to address overstocking of medicines.
- The manager and provider voiced a commitment to continue to try new approaches to recruitment and they agreed to halt admissions to the home whilst new staff were recruited including a deputy manager to support the manager in their role.
- The manager was a registered nurse and had been in post for three months. Staff told us, and we observed, that they were a visible presence within the home and actively supported staff and interacted with people on a daily basis.
- Both relatives and staff expressed a cautious confidence in the manager and in their ability to drive improvements after a very challenging period. One relative said, "The manager has changed, she seems

very good, seems efficient and interested… I do see her regularly when I visit… she makes it her business to know what is going on and the atmosphere has changed now". A staff member said, "[Manager] has been like a breath of fresh aid to Winton, she has already made many positive changes… unfortunately, she came to Winton at a difficult time and has inherited a lot of problems and negativities but I believe given time, she will be able to sort out the problems". Another staff member told us, "I feel our new manger [name] is very approachable and has made a point to be a face the residents know. She has held a residents meeting so any concerns they have they can be raised directly with her. I feel she has come in and really helped all staff and residents".

● Health and social care professionals gave positive feedback about the manager. One said, "I have found [Manager] to be very enthusiastic, proactive and responsive to my communications despite having a lot on her plate managing a new home. She has been encouraging of her new team and keen to learn about them as individuals and how they work together as a team".

● The manager understood the requirements of the duty of candour. This is their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. For example, following a medicines error, the manager had contacted the person's family to apologise and to provide assurances about the actions being taken in response.

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

● Throughout our two days spent at Winton Care Home, staff, and the leadership team were supportive, and the atmosphere was positive. We saw many kind and compassionate interactions.

● People told us staff were all kind and genuinely cared about them. One person said, "Care is super, they look after me a treat, very considerate, very careful, kind and smiley".

● Relatives felt that the longer standing staff knew their family member's well and provided individualised care. One relative said that the staff were "Attentive, really exceptional…he is loved and cared for". Another relative told us, "There is a lot of laughter".

● A healthcare professional said, "Yes I think the staff are excellent with the residents and me as an outsider! I see they are very polite and friendly at all times with the residents, be they kitchen, maintenance, domestic, carers, nurses or reception staff. In fact, it is like one big family and a very happy one… [they are] a super team that working so well to meet the needs of the resident".

● Staff spoke passionately about the parts of their job that were meaningful to them. Comments included, "The staff at Winton care a lot and give a lot", "The best part of my job is the amazing people that I get to work with each day and the residents who continue to make me smile even on a bad day" and "The best part of my job is seeing the enjoyment from the residents… and them smiling knowing I am making a difference to their lives".

● People, their relatives and staff were complimentary about the activities team who they felt were working hard to reintroduce fun and meaningful activities.

● However, whilst staff had a commitment to provide person centred care and were clear about their role and responsibilities, they told us it was not always possible to perform these due to the ongoing staffing challenges. For example, one staff member said, "It isn't always possible to provide the care each resident needs and deserves. This is not only frustrating but at times heart breaking, that I see their needs but am unable to fulfil them".

● Staff spoke of not always feeling valued and raised concerns about low morale and about not feeling engaged or empowered. For example, one staff member said, "The job can be very stressful and tiring and even more so when we are short staffed which affects absolutely everyone in the home whether it's the residents, laundry, cleaners or activities. It makes every aspect of the job that much harder and it can feel like it's impossible to keep your head above water". Another staff member said, "I feel all the staff at Winton are caring and compassionate about their job. I do feel sometimes they feel underappreciated as they all

work very hard and will always go above and beyond for the company". These comments were reflective of those made by a number of staff.

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

● Relatives were able to visit their family members, in line with current guidelines, enabling people and their families to reconnect. Prior to this, where possible, video conferencing services had been used to enable people to speak with their families.

● There was evidence that relatives were updated about their family members wellbeing or changes to their needs. The manager had started sending monthly emails to relatives to ensure they were kept up to date with issues relating to the pandemic, the refurbishment of the home and changes within the staff team.

● People were encouraged to give feedback about the care they received. Residents meetings took place. One person told us, "I chaired a resident meeting about 10 attended, it was difficult to get people to contribute, no main issues, think people are jolly happy way things are".

● The manager had held a general staff meeting which had been used to introduce herself to the staff team and to explore key issues such as safeguarding, learning from incidents and how to provide care safely.

● A staff wellbeing survey had recently been undertaken. The results of this were still being compiled at the time of the inspection.

● The provider gave 'Aces' awards to recognise staff for their commitment to their role.

Working in partnership with others

● The leadership team and nursing staff collaborated with partner organisations effectively and sought out appropriate guidance and advice from health professionals to ensure the safety and wellbeing of people was maintained.

● The manager was currently taking part in the Medicine Safety Improvement Programme which is commissioned by NHS England and Improvement. The programme aims to test and pilot interventions that could be implemented in care homes to improve medicines administration safety.

● The manager responded in an open and transparent way to requests for information to support this inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to manage risk were not sufficiently robust. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not always managed safely. This was a breach of regulation 12 (1) (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not being effective at ensuring compliance with the fundamental standards. The governance arrangements had either not identified or resolved the issues this inspection found. Records relating to people's care and treatment were not always complete, accurate and up to date. This was a breach of regulation 17 (1) (2) (a) (b) (c) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	The provider had not ensured that all of the required recruitment checks were being completed. This was a breach of regulation 19 (1) (a) (b) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were always sufficient numbers of staff deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.