Affectionate Healthcare Limited

Barons Down Nursing Home

Inspection report

Brighton Road
Lewes
East Sussex
BN7 1ED

Date of inspection visit:
06 June 2023
12 June 2023
15 June 2023

Date of publication:
17 July 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Barons Down Nursing Home is a care home with nursing and accommodates up to 30 people in a purpose-built building. The service supports adults whose primary needs are nursing care although some are living with dementia type illness. At the time of our inspection there were 26 people living at the service.

People's experience of using this service and what we found
The providers' governance systems had not identified the shortfalls found at this inspection. Audit systems and processes failed to identify and manage effectively risks to people's safety and other aspects of the service that required improvement. There were areas of people's documentation that needed to be improved to ensure staff had the necessary up to date information to provide consistent, safe care.

Risk management needed improvement to ensure peoples' health and well-being was protected and promoted. We identified shortfalls in respect of the management of risk. For example, the management of incident and accidents. Incident forms were completed but there was a lack of overview, analysis and follow up to prevent a re-occurrence or to mitigate risk. Records were not always clear and accurate regarding people's care and support. Not all staff had the necessary supervision and support to perform their role. The management of medicines was not always safe. Staff were not monitoring the overall effectiveness of pain relief medicine and mood calmers or looking at the times PRN (as and when needed) requests were made for trends or themes. There were not always sufficient, suitably trained and experienced staff deployed.

We have made a recommendation regarding the need to seek advice for the review Deprivation of Liberty Safeguards conditions to ensure they are current and relevant.

People received support from staff who had been appropriately recruited, trained to recognise signs of abuse or risk. One person said, "I do feel safe, the staff are lovely," and "Taken care of, in a kind and nice way I feel very grateful to them all."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The home was clean and well maintained. Infection control procedures were being followed.
The staff were kind in their approach and treated people with respect. Improvements had been made to care plans and they were person-centred and relevant to each person. End of life care planning and documentation guided staff in providing care at this important stage of people's lives. Complaints made by people were taken seriously and investigated.

The registered manager and staff team were passionate about the service and their plans to continuously improve and had plans to develop the service and improve their care delivery to a good standard. Feedback

from staff about the leadership was positive, "We will get there, a lot to do though."

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 May 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by our data insight that assesses potential risks at services, concerns raised and based on the previous rating. This enabled us to review the previous ratings. We also used this opportunity to look at the breaches of Regulation 9 and 17. As a result, we undertook a focused inspection to include the safe, responsive, and well-led key questions. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

The provider and management team took immediate action during the inspection process to mitigate risk.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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**

Barons Down 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection team consisted of three inspectors.

Service and service type
Barons Down Nursing 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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.
At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service and the service provider. We looked at the action plan from the previous inspection, notifications, and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law. We also sought feedback from the local authority and professionals who work with the service.

The provider was asked to complete a provider information return prior to this inspection. It was completed 24 July 2022. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We looked around the service and met with the people who lived there. We used the Short Observational Framework for Inspection (SOFI) during the morning of the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 12 people to understand their views and experiences of the service and we observed how staff supported people. We spoke with the registered manager, area manager, deputy manager and 7 further staff members. This included care staff, and ancillary staff.

We reviewed the care records of 9 people and a range of other documents. For example, medicine records, 4 staff recruitment files; staff training records and records relating to the management of the service. We also looked at staff rotas, and records relating to health and safety. We continued to seek clarification from the registered manager and provider to validate evidence found. We spoke with 3 relatives and 4 health care professionals and completed these discussions on 15 June 2023.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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: Learning lessons when things go wrong

- Risks to people's health, safety and welfare were not always safely managed. Whilst there were in depth care plans and risk assessments to guide staff in providing safe care, they were not all up to date and not reflective of the care they were receiving. However, when discussed with staff, the knowledge they had of people mitigated the risk. This has been further discussed in depth in the well-led question.
- During the inspection, we found one person at risk of harm by trying to climb over their bedrails. In the persons' care records, there was information recorded within the deprivation of liberty safeguards that this person should not have bed rails in place, but a crash mat. There was no bed rail assessment in place to say that this decision had been discussed and bed rails were a safe option for them. The person also had had 8 injuries, skin tears and bruises to limbs in April 2023 which had not been considered as a contributory factor of contact with the bed rails when agitated.
- There were 33 incidents with injuries (excluding pressure damage) in April 2023 and 28 incidents (excluding pressure damage) in May 2023. The overview of incidents/accidents was not robust, there was no initial record of any action taken to prevent re-occurrences, tracking times or places/equipment involved to monitor trends or themes. This placed people at risk of harm.
- Due to the number of repeated incidents, we were not assured that lessons were always learnt. For example, the staff were aware that one person had had repeated falls for a specific reason, and that it was important for that person to maintain their independence. Staff had not sought expert advice, they had not discussed any alternatives to this situation. The risk assessment for this person did not reflect their current situation
- There were people with wounds. There was documentation in place that had identified the wounds, however not all records followed the national institute for clinical excellence (NICE) guidance. For example, photographs of wounds were not always labelled and measured, there was minimal information recorded regarding the status of wounds for example, assessment of wound, discharge, redness, or wound colour. This was fully discussed due to the importance of tracking wounds to ensure they are healing.
- The service had a suction machine in the clinical room that was to be used for emergency situations, such as seizures and to assist in supporting people at their end of life. They currently supported people who live with epilepsy and seizures and people receiving palliative care who may need to use the machine. However, the clinical check list completed stated it was not working. On discussion with the registered manager, we were told that it was working but staff did not know how to use it. The suction machine was immediately withdrawn from use until staff had received appropriate training.

The above evidence shows that care and treatment had not always been provided in a safe way. Risk of potential harm to people had not always been mitigated. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. We received the care plans and risk assessments identified as in need of urgent attention to ensure safe care delivery, these had been reviewed and updated. External training with the tissue viability community team had been arranged and confirmed.

● Risks associated with the safety of the environment were identified and managed appropriately. This meant the provider could be confident that risks were mitigated.
● Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP).
● There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. The documentation supported that each DoLs application was decision specific for that person. For example, regarding restricted practices such as locked doors, sensor mats and bed rails. We saw that the conditions of the DoLS had been met.

The registered manager was not in agreement with some of the conditions. We have recommended that they seek further advice if they are not in agreement with the DoLS conditions and ensure that this is clearly defined within the care documentation.

Using medicines safely
● Medicines were not always stored, administered, and disposed of safely.
● The clinical room was not clean; the floor and walls were dirty. The room was disorganised, boxes of discarded medicines took up a lot of space and were not sealed for safety. There were old records intermingled with recent records on the shelves.
● Medicine administration records (MAR) were poorly completed, and signatures crossed out and unreadable. Verbal and written changes to prescriptions were not always signed and countersigned to mitigate human error.
● There was a large number of medicines returned unopened, which had been dispensed for people in May 2023. On tracking these with the May 2023 MAR for those people, we could not be assured that the people had received their medication as prescribed.
● Protocols for 'as required' (PRN) medicines such as pain relief and mood calming medicines were not in place for everyone. People had received pain relief when requested, but there was no reflection of the

effectiveness of the medicine. Medicines had been given for mood calming but there was no corresponding management chart as to why it was required or the effectiveness of taking the medicine, it was not clear if distraction techniques were tried before the medicine.
● There were people who received their medicines covertly (hidden in food).There was documental evidence of appropriate best interest meetings held with the GP and dispensing pharmacist. However, on discussion with staff they were not aware of the procedures regarding administering covert medicines and whether the person's preference for taking medicines with food was covert.

The provider had not ensured the safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff who administered medicines had received the relevant knowledge, training, and competency assessments. This included senior care staff as well as registered nurses. We observed staff administering medicines safely to people ensuring that they were offered the medicines, given time to take them in the way that they preferred and signed for once they were taken.
● Medicines were stored in a lockable room, that was kept at the right temperature, which staff recorded daily. Clinical fridges were clean and were kept at the recommended temperature.

Staffing and recruitment
● There were not always enough suitably qualified, competent, skilled, and experienced persons deployed to support people safely. People told us, "The staff are lovely, but they have to rush, they have no time to chat," and ""All fine. Carers are nice. Never rude. They don't come and chat with me, they always have something to do," and "They can be a little slow coming to the buzzer. Different times can be busier than others. Morning and just after lunch are particularly bad sometimes. The staff are very busy. They don't have time to stop and chat with me or stop and sit with me. It's not their fault they just don't have the time. I don't often get out of bed, it's too much effort," and "It's not my choice to stay in bed, no time."
● The night time staffing levels were not sufficient to ensure people's safety in the event of an emergency. The rota showed there was 1 registered nurse and two care staff to cover three floors and 26 people. Most of the people supported had complex needs with mobility needs.
● The allocation, deployment of staff meant that at certain times, 4 of the 6 staff were on the middle floor, and no staff on the ground floor apart from the activity staff member. The reasoning for this was the number of people being divided amongst 6 staff. However, this had the potential to impact on staff monitoring people's safely and response times to call bells.
● Staff had not had the appropriate support, training, professional development, supervision, and appraisal necessary to enable them to carry out the duties they were employed to perform. The supervisions for staff had lapsed and recommenced in March 2023.
● Newly qualified nurses who had recently completed their objective structured clinical examination (OSCE) had not received appropriate support to build their confidence and to work under supervision in some aspects of care home working. For example, medicine systems. This had impacted on safe medicine management.
● The training matrix showed that staff had completed on-line training, and competencies had been undertaken. However, at the time of this report the competency assessments had not been provided.
● The staff told us, "More staff would let us do our job better, to spend time with people, especially when they stay in their room."
● Looking at the overview of accidents and incidents, people's, and staff comments, the current staffing levels were not always sufficient to meet peoples' needs consistently.

The provider responded immediately during and after the inspection. The impact on people has been

mitigated. The provider increased the staffing levels both during the day with an extra registered nurse and at night with an extra staff member. Supervision for staff had been done, including the registered manager and deputy manager. The deputy manager had immediately supervised medicine givers supported with an action plan to go forward. Due to the immediate actions taken and the mitigation of risk, we have reflected this in more depth in the well led question with a breach of good governance.

● Staff were recruited safely which had ensured that only suitable staff were employed to work at the service. Pre-employment checks included those undertaken with the applicant's previous employer in care and the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
● Registered nurses are required to register with the Nursing and Midwifery Council and the provider had systems in place to check their registration status.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse and avoidable harm. People we spoke with, told us that they felt safe with all the staff who supported them. One person said, "They are kind, and make sure we are safe," and "Been here for 3 years. Taken care of, in a kind and nice way I feel very grateful."
● Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns and make the required referrals to the local safeguarding authority. The registered manager was aware of their responsibilities for reporting concerns to the CQC.
● Information was available for people and for staff regarding adult safeguarding and how to raise concerns. Information was provided in an appropriate format to enable people to understand what keeping safe means and how to raise concerns. One person said, "I'm not sure who the manager is, but I would tell staff if I was worried or felt frightened." A staff member told us, "We have training and we can access information in the office."

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

At the time of the inspection there were no restrictions for relatives and loved ones visiting people.

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 requires improvement. At this inspection this key question has improved too good.

This meant people's needs were met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences: Meeting people's communication needs

At our last inspection the provider had not ensured that peoples' care and treatment was appropriate to their needs or reflected their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection to meet the breach of regulation 9.

- The newly registered manager was in the process of reviewing care delivery, risk assessments and care plans. Care plans and treatment plans reflected people's individual care needs. Improvements had been made since the last inspection in respect of exploring why people were on continued bedrest, foot care and the management of peoples' pain and topical creams.
- The level of information regarding their individual needs of epilepsy, diabetes, medicines, and communication was good.
- At the last inspection we found concerns regarding oral care. This inspection found that whilst there were toothbrushes and toothpaste in many people's ensuites there was still some work to do to ensure there was a consistent approach to oral health.
- Improvements had been made to the provision of activities, there were planned baking sessions, a gardening club and tea meetings. People told us, "She (activity person) is lovely, we do enjoy ourselves, we are baking today." Another person said, "The staff really try to provide us with things to do, but I don't really think it's for me, but they always offer to take me down."
- The registered manager explained that the activity person had left since the last inspection but had seen that a member of the administration team was excellent in that role and knew the people well. Activities were provided daily during the week, but there were plans to extend the provision.
- People told us they were offered the opportunity to join activities in the communal areas and there was evidence that the activity person visited people in their rooms. The registered manager told us of plans to have added communal areas on each floor for those that did not want to go to the communal area. Following the inspection, we were informed that furniture for the middle floor had arrived.
- Records now included specific details of activities people had engaged in during the day, which had provided important insight for staff.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.

● People's communication needs were met. Staff confirmed they had received training on the accessible standards, and there was guidance in care plans about people's communication needs. There was evidence that not all staff were experienced in using communication aids, such as pictorial Makaton and this was training that was to be sourced.

● Technology was used in the home for some people to communicate internally with staff using the call bell system and externally using landlines or mobile phones to talk to and receive calls from relatives and friends. There was a broadband system in place and people could be supported to use this to contact relatives using skype and emails.

Improving care quality in response to complaints or concerns

● A record of complaints was held in the service. These included the information on the complaint and how this was responded to. We saw complaints had been responded to and actions taken as necessary. This was used to improve the quality of care.

● People and their relatives confirmed they knew how to make a complaint. One relative said they had spoken to the registered manager and the problem had been 'sorted' before needing to make a formal complaint. People told us they knew how to make a complaint. One person said, "I speak to the staff, and they take it to person in charge."

● The registered manager told us, "We take all complaints seriously, we want to get it right."

End of life care and support

● When people needed end of life care, staff worked closely with other health care professionals to provide the best care for people in a compassionate way. The community care home matron was closely involved with the service. All staff received palliative care training as part of their training programme.

● Staff delivered care that took account of people's wishes and supported their comfort. Staff were caring for people during the inspection that were approaching the end of their life. They were respectful and caring, and the person was kept comfortable and pain free.

● Care plans identified people's preferences at the end of their life and the service co-ordinated palliative care in the care home where this was the person's wish. Care plans contained information and guidance in respect of peoples' religious and resuscitation wishes.

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 requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to access, monitor and mitigate the risks relating to the health, safety and welfare of service users and to maintain accurate, complete and contemporaneous records which was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was a new registered manager in post (since late February 2023), who was committed to making improvements. They were aware of the improvements required and had devised an action plan with the providers. The existing systems of governance and audits however were not effective.
● Care plans and risk assessments whilst improved and person centred, as acknowledged in the responsive question, were not all up to date and therefore placed people at risk of unsafe care. For example, one person's care plan had not been updated/changed to reflect their deterioration in mobility, mental health, and social life. Another person now had a catheter, and there was no guidance for staff to follow or risk assessments in place to ensure staff were aware of possible complications.
● Food and fluid charts were not all accurate or consistently recorded. Some records showed that some days a person drunk 1300mls but on other days 500mls. This was not highlighted for staff to follow up leaving a potential of the person becoming dehydrated. There was a lack of oversight to ensure people had enough to drink.
● There were discrepancies in mental capacity assessments for specific elements of care. For example, regarding the use of covert medicine and peoples' preferences for remaining on bed rest. The management team were new in post and had not been involved in some of the assessments. They confirmed that this was a priority going forward.
● We found records relating to individual care delivery were not all complete and up to date. For example, information regarding personal care, food, and fluids. Risk assessments were not always completed or updated in a timely way following accidents and incidents to reduce the risk of a recurrence. The overall

monthly accident and incident tracker did not evidence analysis of times, locations and actions taken.
● Records showed that staff had not been having regular supervision sessions and competency assessments. We were not assured that all new staff had had a thorough induction and introduction to the service. For example, the deputy manager and registered manager had not had a supervision since their employment. This had not given them the opportunity to discuss and formalise their job role, what support was needed or how to develop their role and the staff team.
● Not all newly qualified staff (OSCE) had had the necessary introduction to their role, there were areas of clinical governance that needed to be introduced to ensure safe practice and care delivery. For example, the use of emergency equipment, management of medicines and wound care within the care home setting. This relates to building knowledge and confidence in managing these in a safe way.
● Not all job roles at present were clearly defined and staff were working outside their role. The activity person was allocated hours to do activities but also worked as an administrator in the office. These hours were not defined on the staff rota. The deputy manager had two hours a day allocated to the deputy role, but also worked as a care staff member. This had impacted on improvements to the running of the service. Two cooks/chefs had been recruited but in the meantime a care staff member was allocated to the cooking role with other staff cooking at weekends. This included the registered manager.
● Staffing levels were not reflective of peoples' increased dependency and deterioration of health. Staff met peoples' needs in a task orientated way but people at times were left feeling isolated and this had a potential impact on their mental health.
● There was a high use of CCTV cameras throughout the premises, in corridors, communal areas, and in all staff areas. There were no signs informing people and visitors of the CCTV cameras. There was a need to consult with the people who use the care service, including residents, families, and other visitors to care homes and staff when deciding about whether and how to use surveillance.
● Some window restrictors did not meet the health and safety guidance, which placed people at risk.

The provider had failed to assess, monitor, and improve the service. The provider had failed to assess, monitor, and mitigate risks to people. The provider had failed to maintain accurate, complete, and contemporaneous records. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider responded immediately during and after the inspection. They had updated care plans and risk assessments, all people on fluid checks had been reviewed, the incidents will be looked at and discussed daily, as they happen, and a root cause analysis will take place once week as needed. The deputy manager will be supernumerary for a fixed amount of time to ensure new staff were supported in their role and introduced to the complexities of working in a care home, ensuring they felt safe and confident in their role. Staffing levels had been increased at night to ensure the safe running of the home. There were now signs advising people, staff, and visitors of the CCTV in the premises. Window restrictors were immediately actioned.

● Staff talked positively of their job and the people they supported. Comments included," There has been a lot of staff changes, new staff and different managers over the past few months," "More time and support would be good, but we are building a good team." Staff meetings were held regularly and included a daily meeting with all new staff to discuss changes and allocation of work.

Working in partnership with others: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider was working with external professionals from health and social care services to improve and develop the service. This included the Continuing Health Care (CHC), Clinical matrons for care homes, local

authority, and the medicines optimisation for care homes team to make and embed improvements in the home.
● Questionnaires had been sent out in January 2023 to gather feedback from people and families. These included food quality, activities, and cleanliness. The provider had analysed responses and responded to people to tell them what improvements were planned to follow their feedback.

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; Continuous learning and improving care:
● The provider understood duty of candour, working openly and honestly with people when things went wrong. The registered manager was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest, and transparent with people and others in relation to care and support. The service had notified us of all significant events which had occurred in line with their legal obligations. One health professional told us, "Communication is on-going, they have contacted us for advice on training opportunities."
● The registered manager told us they used incidents, complaints and safeguarding as learning tools to improve the service. Staff told us, "We are told of what we need to do, to improve."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (b) (c) The provider had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a). The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).