

Coate Water Care Company Limited

Avebury House

Inspection report

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

Summary of findings

Overall summary

About the service

Avebury House is a nursing home in Devizes for up to 41 people. Accommodation is provided over two floors accessed by stairs and a lift. People have their own rooms and access to communal rooms such as lounges and dining areas. People can access the garden from the ground floor. At the time of the inspection there were 31 people living at the home, some of whom had dementia.

People's experience of using this service and what we found

People did not always get their medicines as prescribed. Whilst we observed staff administering medicines safely, medicines stock did not tally with totals recorded in medicines administration records. Records for topical cream applications had gaps in recording which meant the provider could not be assured creams had been applied consistently.

Risks to people's safety were not always managed safely. Where people were at risk of pressure damage or malnutrition, we were not able to see consistent action taken to mitigate risks.

Records were not always an accurate account of people's care and support. When people experienced distress there was no record of what staff did in response. Kitchen staff did not have accurate and up to date records for people's needs, likes and dislikes. This meant people were at times given food or drink they did not like or want. Quality monitoring systems were not effective in identifying and driving improvement in all areas. Systems had not identified all the shortfalls found in this inspection.

At times there were not enough staff available. This was due to short notice sickness which the provider struggled to cover. Agency staff were being used but not always available at short notice. Recruitment had been successful and new staff were getting ready to start. This meant the service would not need to use agency staff to cover gaps in staff rotas. We have made a recommendation about staffing.

Staff were being recruited safely with all the required checks being completed prior to staff starting work. People were supported by staff who had been trained and were being supported by management. All staff we spoke with enjoyed working at the home and liked their jobs. Staff morale was high and there was good teamwork evident.

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. People were involved in their care and had their own care plan which had been personalised. People told us they felt safe at the service.

Government guidance in relation to testing for COVID-19 was being followed. We observed staff to be wearing personal protective equipment (PPE) as needed. Staff had received training on working safely during COVID-19 and there was guidance available on good practice such as washing hands thoroughly. The

home was clean and domestic staff were employed to ensure all areas were cleaned regularly.

During our inspection the service experienced a COVID-19 outbreak. Management contacted the local health protection agencies to follow current guidance on steps to take.

Staff morale was good and there was good teamwork evident. Communication systems were in place to make sure staff were updated with events and incidents. Staff received training including an induction when they started work. Staff told us they felt supported and able to approach the management with any concerns or ideas.

Systems were in place to manage complaints and learn from any feedback. The new manager was hoping to make some improvements to key areas such as upskilling staff, care planning system and daily recording. The manager told us they were applying to register and felt supported by the provider.

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 28 April 2021).

Why we inspected

This inspection was carried out as part of our planned inspection schedule.

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 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 will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, risk management and systems of good governance at this inspection. 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 and 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 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 not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Avebury House

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 Health and Social Care Act 2008.

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

This inspection was carried out by three 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 care service.

Service and service type

Avebury House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. [Care home name] is a care home [with/without] nursing care. 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. A new manager had taken over the day to day responsibility of the home and was in the process of applying to become registered. They were being supported by the registered manager and will be referred to as "the manager" in the report.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service including notifications the provider submits about specific incidents and events. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection

We spoke with 10 people and one relative about their experiences of care and support received. We spoke with eight staff, the manager, the registered manager and one director. We reviewed three staff files in relation to recruitment, 10 people's care plans and risk assessments, multiple medication records, health and safety records, daily notes and monitoring records and quality assurance records.

After the inspection

We spoke with a further six relatives and seven members of staff on the telephone. We continued to review and validate evidence found. We reviewed quality monitoring data, meeting minutes, infection prevention and control audits and policies.

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 focused inspection, we rated this key question good. At this inspection the rating has changed 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.

Using medicines safely

- Medicines were not always stored safely. We observed thickening agent was stored in people's rooms. This meant it was accessible to people living with dementia who may not understand the risks. We informed the manager of this concern and were told safe storage would be bought to keep thickening agents secure. However, on day two of our inspection we observed thickening agent for one person was still being stored insecurely.
- We observed for two people, their medicines stock was not consistent with amounts recorded on their medicine's administration records. This meant we could not be assured people had their medicines as prescribed. We informed the manager during our inspection of this discrepancy.
- Systems were not robust to make sure staff were consistently recording when they applied people's creams. We observed staff were recording application of creams in people's daily notes and on personal hygiene records. There were gaps in recording which meant the provider could not be assured people had their creams applied when and where needed.

Failing to manage and store medicines safely put 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.

- Staff had received training on medicines management, and we observed they were administering medicines safely.
- Temperature checks of medicines storage cupboards and fridges were being recorded and demonstrated temperatures were within a safe range.

Assessing risk, safety monitoring and management

- Risks to people's safety were not being managed consistently and safely. Where people had been identified as being at risk of developing pressure ulcers, management plans were not clear or consistently being followed.
- For example, for one person who had been identified as being high risk of developing pressure ulcers, we observed there was no guidance for staff to know how often the person needed re-positioning. A re-positioning record was in place, but we observed there were gaps of up to six hours on some days. For another person, we observed they needed re-positioning every four hours. We observed gaps in the records of up to eight hours on some days. In addition, this person was not to be re-positioned on their back. We observed in one week this person was positioned onto their back on nine occasions. We shared this information with the manager.
- One person had been assessed and identified as being high risk of malnutrition. We observed they had

lost weight which had not been reflected in their nutritional management plans. We raised this with the manager who told us this person would be weighed weekly to monitor for any further weight loss. In a period of six weeks, this person was weighed once. This placed them at risk of harm.

- Kitchen staff did not have up to date information about who was at risk nutritionally. This meant they were not able to make sure these individuals consumed a diet with more calories to help them with weight gain. The registered manager told us they would share information about who was at risk of malnutrition at the daily 'head of department' meeting.

Failing to take action to make sure risks were mitigated 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.

- The service used a system called 'resident of the day' which helped them review risk management plans when needed.
- Systems were in place to make sure premises and equipment was serviced and maintained regularly. Fire systems were checked regularly, and external contractors were sourced to service items such as lighting and lifting equipment.

Staffing and recruitment

- People had mixed views on staffing numbers at the home. Some people told us there were times when there were not enough staff. Comments included, "I think there could be more staff, sometimes I have to wait a long time to get the care I need. I sometimes feel I don't get cared for on time", "They are so short staffed, I get stressed sometimes and a bit anxious" and "They [staff] come when they can, sometimes you might have to wait a bit, it depends if they are busy. They can't drop everything just for me or they would be dropping something all of the time."
- Some people thought there were enough staff. Comments included, "I think they probably have the right number of carers, they help each other when needs be" and "I think the numbers are about right although I do note some of the times they [staff] are rushed and have lots to do."
- Staffing had been a challenge for the provider due to short notice sickness. Whilst the provider tried to obtain staff from local agencies, there were not always staff available at short notice.
- On our first day of inspection three members of staff had called in sick. Finding replacements to cover gaps in rotas took time which meant for the start of the day there were not enough staff available. One member of staff told us, "We are not short of staff, it is just a lot of sickness, but we are all happy to help out."
- The manager told us recruitment was ongoing and there had been successful appointments made. New staff would be starting work to boost numbers of permanent staff available. In the interim period the service would continue to work with local agencies to cover gaps where needed.
- Systems were in place to make sure staff were recruited safely. The provider obtained the required information for all staff prior to employment starting. This included references from previous employers and a check with the disclosure and barring service (DBS).

We recommend the provider reviews staffing numbers on a regular basis to include listening and using the feedback from people about their experiences of care.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt safe at the home. Comments included, "I do feel safe living here, because that is what I feel, that I am safe", "I do feel safe" and "I feel very safe. I say that because I am well looked after and they [staff] make sure I'm safe, like making sure I have a bath and I have the alarm system

too."

- Systems were in place to make sure safeguarding incidents were reported to the local authority and action taken to keep people safe.
- Staff were clear about their role in safeguarding people and told us they would report any concerns to the management. Staff were confident management would deal with any concern appropriately and in a timely way.

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 meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- 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.

Visiting in care homes

- People were able to have visits from friends and family. People had essential care givers who could visit during outbreaks. Visitors were also asked to wear PPE as appropriate.

Learning lessons when things go wrong

- Incidents and accidents had been recorded. These were reviewed by management to identify any learning.

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.

This is the first comprehensive inspection for this registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People and their relative's views about meals and food available were mixed. Comments included, "I like the food on the whole. Some things I don't like, but there is always an alternative", "The chef is wonderful, she really does good food, she is one of the best", "The food isn't first class but it is okay, if I don't like it I just leave it. I don't ask for an alternative. We don't usually get a choice or see a menu" and "The food is okay, I suppose. The glasses and cutlery are usually dirty, it is not good, and it puts me off."
- We observed people had a choice of meal, there were menus prepared but not available to people in all their rooms. Meals looked and smelt appetising. We observed one person asked for a glass to have a drink and the one staff brought was dirty.
- We observed people's preferences about food and drink were not always available to kitchen staff. Kitchen staff had a folder with a preferences form for each person, however, this was not up to date.
- This meant the kitchen did not have a record of likes and dislikes with regard to food and drink which was a concern for people. Comments included, "I don't like salad but the kitchen still bring in salad for me", "I mind if it is shredded [lettuce] because it always gets stuck in my teeth but they [staff] always give me shredded leaves" and "[relative] doesn't like baked beans but seems to have them three times a week. I would like there to be menus and choices. [relative] is not happy with the food."
- We discussed the concerns with the management who told us they would address the shortfalls to make sure the kitchen staff were updated and had the information they needed.

Whilst we did not observe people were harmed, failing to have systems in place to update the kitchen staff with people's likes and dislikes for food and drink did not demonstrate good governance. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were supported by staff who had been trained. A range of training was available to staff to give them the skills and knowledge they needed for their roles.
- New staff had an induction when they started work. This included training and shadowing more experienced staff. One member of staff said, "I'm very eager to learn and they [provider] promote that. It [induction] was great for me."
- We reviewed the training matrix and saw there were staff who required an update for some areas. The manager told us updates were being planned but as staff needed an update at the same time, it had to be staggered due to needing staff to work in the home.

- Staff told us they felt supported in their roles and were able to have supervision on a regular basis.
- During our inspection a new clinical lead started work at the service. Part of their responsibilities was to plan and deliver clinical training to nursing staff and upskill senior care staff to work effectively.

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

- People were assessed prior to admission to make sure the service could meet their needs. Assessments of needs were then ongoing to keep people's care plans up to date.
- Assessments included physical health needs and mental health needs to give staff a full assessment of people's whole health.
- Staff used nationally recognised assessment tools such as the Waterlow assessment tool for assessing people's risks of developing pressure ulcers.
- People had oral health assessments which recorded their needs in relation to oral care and hygiene.

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

- Staff had daily handovers to share information on people's needs. This included a daily heads of department meeting to discuss events for the day, incidents and accidents and any other significant changes.
- Referrals to health professionals were made in a timely way. People could see visiting health professionals such as GP's, community nurses and social workers. We observed a professional visiting during our inspection. They were visiting people in the 'discharge to assess' rooms which people used to help increase timely hospital discharges.
- Discharge to assess rooms were commissioned by the local authority for people to use on a short stay basis. Whilst in the home a range of professionals visited people to help with support needed to move back to their own homes.

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

- The home was purpose built and was maintained and decorated. People had their own rooms which they could personalise if they wished. One person said, "I had choice of all the rooms, I am glad I chose this one. I like the view to the gardens; I have a phone and it is a nice cool room which is what I like."
- Communal rooms were available for people to use such as lounges, dining rooms and there was a garden area accessed from the ground floor.
- Corridors were wide so people could move about easily including those that used wheelchairs. Handrails were available in corridors and bathrooms, so people had support to use facilities independently.

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 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 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 found they were.

- Staff were familiar with the principles of the MCA and how it applied to their jobs. People were supported

to make their own decisions where appropriate.

- The home had submitted DoLS applications to the local authority to be assessed. At the time of our inspection, no assessments had been carried out.

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.

This is the first comprehensive inspection for this registered service. This key question has been rated 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

- We observed people being treated with kindness and respect on both days of our inspection. People and relatives told us they felt they were well cared for. Comments included, "I think [relative] is well looked after, I have been down to visit, and I have witnessed them [staff] looking after [relative]. [relative] is comfortable living there and certainly doesn't want to leave", "[staff member] is lovely, she chats with me and does my nails for me" and "We are very pleased, [relative] is well looked after and they [staff] are very caring."
- Some people talked to us about the attitude of some agency staff. People were not always happy with how they cared for them. We shared this with the manager who told us they were nearly fully staffed and would not be using agency staff in the near future.
- Staff had access to information about people's life history and life events which helped them communicate with people and understand their needs.
- In addition to treating people with kindness and respect we observed staff treating each other with respect. There was good communication amongst the team which helped them meet people's needs. One person said, "They [staff] help each other an awful lot. [staff member] is a jack of all trades. She helps out and runs the kitchen when [chef] is away and she covers as cleaner too."

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

- People were involved in their care and were able to make day to day decisions. People chose where to spend their time and who they wanted to see.
- Whilst we observed there were times staff were short of numbers, we observed care was delivered in a relaxed and unhurried way. Staff took time to talk with people and offer assurance where needed. One person told us, "The carers are very busy, but I don't regard that they rush their tasks." One relative told us, "The staff are always very pleasant, I think [relative] is getting reasonable care, the staff are always attentive."
- Where needed people could access advocacy services to help them be involved in their care. We observed people had access to social workers from the local authority where appropriate.

Respecting and promoting people's privacy, dignity and independence

- People received care that promoted their privacy and dignity. Staff tried to promote independence where possible and encouraged people to do as much for themselves as they could.
- We observed staff knocking on people's doors before going into their rooms and making sure doors were closed when helping people with personal care.
- People could have visitors in their rooms. We observed relatives visiting during our inspection following

the government guidance on visits in care homes.

Is the service responsive?

Our findings

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

This is the first comprehensive inspection for this registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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 and relatives told us they thought there could be more activities and opportunities for social engagement available. Comments included, "There are activities here but not enough. I expect that is partly a feature of COVID-19, but I think they could do more, to be honest", "I do get in my wheelchair and I do go to the lounge but it is always very quiet there. It is so unfortunate that there is never anyone there, it is a shame that there are not more people that I could talk to" and "I stay in my room, it is so quiet here."
- We observed people chose to spend their time in their rooms which meant the home was quiet in communal areas. On our second day of inspection people were isolating in their rooms due to an outbreak of COVID-19, however, we did not observe any difference to our visit when the home was not in outbreak.
- Some people did not have their needs and wishes recorded with regards to social activity and the service was not recording when people engaged with or participated in activities. This meant the service did not have an accurate record of what people had done throughout the day.
- An activity worker was employed and carrying out some activities such as 1-1's in people's rooms and craft-based activity. However, none of their work was recorded in people's notes.
- The manager told us they had photographs of people doing activities but had not implemented any system to capture and record how people spent their time. The manager also told us they had employed another activity worker who was nearly ready to start work.

Whilst we saw no evidence of harm, failing to have a complete and contemporaneous record for people was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People had a care plan which was personalised and recorded information on a range of needs. The provider used an electronic care planning system which staff could access from handheld devices.
- We observed some of the information recorded in people's notes was not accurate. For example, for one person staff had recorded they had a pressure injury. When we asked about the pressure injury, we were told this was not accurate. The person did not have any pressure damage. For another person, staff had recorded they had been out to a café. The person was end of life, so we checked if this was accurate. It was not accurate as staff had pressed the wrong buttons on the system.
- We also observed for one person there was no record of support given in response to their distress. For example, on one day staff had recorded the person was 'shouting for help and screaming, agitated and awake'. It also recorded the person was content. There was no other information recorded to demonstrate

action taken by staff to support the person's distress. On another day staff had recorded the person was in bed and shouting. They did not record what action they took in response. We talked with the manager about this who told us staff always provided reassurance to the person and they had been seen by their GP for a review of medication.

- The manager told us part of the recording issue was a shortfall of the electronic system being used. For some areas it requires staff to press a button to move on through the system. The manager told us they would raise this with the provider of the care planning system as a design fault. They told us the organisation was receptive to feedback from users of the system.

Whilst we saw no evidence of harm, failing to have an accurate, complete and contemporaneous record for people was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- People's communication needs were recorded in their care plans. Any additional support people needed to communicate was recorded.
- The provider was able to provide people with information in different formats if needed.

Improving care quality in response to complaints or concerns

- The service had a complaints policy in place with timescales for responding to any complaints received.
- Complaints had been recorded and responses provided to complainants. This included details of how to escalate complaints to the local government ombudsman.

End of life care and support

- People were not always supported to record their end of life wishes and preferences. During our inspection we were told two people were end of life. Whilst one person had their wishes recorded, one person did not. The manager updated this during our inspection.
- The provider told us they were working to improve end of life care at the home. The new clinical lead would be providing staff with specific end of life care training which would include oral care at end of life.
- People were supported by healthcare professionals to help manage pain and assess skin. Where needed people had access to end of life care medicines to help them remain comfortable
- People were able to have visits from family and friends at the end of life in line with government guidance.

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 our last focused inspection, we rated this key question good. At this inspection the rating has changed 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

- Quality systems were not effective or robust in identifying and driving improvement across the service. Shortfalls we found during our inspection had not been identified by the provider so that improvement plans could be put into place.

- For example, discrepancies with medicines stock had not been investigated to find out the causes. Quality audits had not identified the lack of recording for social activity or the failure to record responses to people's distress. Systems were not in place to make sure the kitchen staff had up to date information about people's likes and dislikes with regard to food and drink.

Failing to have systems in place to assess, monitor and improve the quality and safety of the service and to mitigate the risks in the service placed people at risk of harm. This was a breach of Regulation 17 (good governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During our inspection we were able to talk with the registered manager and the new manager employed to be registered at the home. The registered manager had moved to another home managed by the provider. The new manager had applied to be registered with CQC and was being supported by the provider and the registered manager.
- Notifications had been sent to CQC as required to do by law.

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

- People, relatives and staff knew who the management at the home were and felt able to approach them. Comments included, "I always have a laugh with [management]", "[manager] seems nice" and "I am content in the workplace and the residents seem to be content. I am proud I can go to my manager if I am worried about anything."
- We observed management led by example and were visible working with people and staff.
- Staff morale was good, and we observed evidence of teamwork. One member of staff told us, "We provide a great service to our residents and we work as team; we support each other; it's a nice place to be. The atmosphere, the staff, the home is lovely – it is all just nice."

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

- Systems in place for seeking and acting on feedback from people to improve the service were not robust. For example, kitchen staff told us they heard from staff if there were any issues with the food. Whilst staff can share some comments they have heard, there was no formal system in place to gather feedback about the food and drinks. This meant improvements could not be identified to address shortfalls we heard from people.
- We observed minutes from one 'residents meeting' but many people had declined to attend. We were not able to see any alternative in place for people to share their views about the management of the service.
- Staff had opportunities to update themselves on changes to guidance or systems and to share their views on working at the home. One member of staff said, "Everything is very clear and there is always lots of communication."

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 provider and registered manager were aware of their responsibilities to be open and transparent when things went wrong at the home. Systems were in place to make sure the duty of candour process would be followed.

Working in partnership with others

- Staff worked with other professionals to make sure people's health needs were met. Evidence was recorded in people's notes on action needed and outcomes of visits and consultations. One professional told us, "There is good communication and good collaboration here. Staff work well with us and are always keen to help."

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
Treatment of disease, disorder or injury	<p>The provider failed to take action to mitigate people's risks. The provider failed to make sure medicines were managed safely.</p> <p>Regulation 12 (1) (2) (a) (b) (g)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The provider failed to have effective systems in place to assess, monitor and improve the quality and safety of the service. They also failed to have systems in place to assess, monitor and mitigate risks to people's health, safety and welfare. The provider failed to maintain an accurate, complete and contemporaneous record for each person at the service.</p> <p>Regulation 17 (1) (2) (a) (b) (c)</p>