Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Wingfield is a care home providing personal and nursing care to 89 people. Some people are living with dementia. The home is made up of two buildings, three separate communities. The Lodge, Memory Lane (Dementia Care Unit) and general nursing community. At the time of the inspection there were 58 people living at the service.

People's experience of using this service and what we found
The home had experienced various changes in management, with three different managers in quick succession. This had caused inconsistent oversight and leadership, and low staff morale. The newly appointed manager confirmed the home was on a journey, but currently, it was not where they wanted it to be. They said the culture of the home had improved, and a stricter admission criterion had been adopted. This had enabled some stability, to minimise the pressure on the staff team.

People, their relatives and staff told us there were not enough staff. This impacted on the quality of care provided which meant people were waiting to use the toilet and were not able to get up and go to bed when they wanted to. Some people walked around the home and went into other people's rooms. Staff were not aware of their whereabouts. This impacted on people's safety.

In addition to care staff shortages, there was a shortage of housekeeping staff. This had put additional pressure on the housekeeping team and limited the amount of cleaning they could do. The manager confirmed focus was being given to housekeeping and care staff recruitment, with the aim of being fully staffed without needing to use agency staff.

Staff did not wear their masks correctly and some staff also wore stoned rings, bracelets and nail varnish. This compromised good infection prevention and control. The kitchenette in The Lodge was not clean as there was debris on the floor and walls, and there were dirty cups in the cupboards.

Care planning did not always take into account people's needs and preferences. Staff did not have written guidance to ensure people received effective support whilst experiencing distressed behaviours. Some monitoring records were not completed in real time, which meant there was a risk they were not accurate. Other records lacked detail so could not be accurately analysed. Some daily records contained disrespectful language and a lack of understanding of people's needs.

People and their relatives told us there was not a lot to do in the home. Two new activity organisers had been employed to address this. They were beginning to get to know people, to help plan activities in line with personal preferences. Due to the relaxation of government guidance regarding the pandemic, people were able to receive visitors as they wished.

The service was experiencing difficulties with the supply of medicines. This had particularly impacted on one

person, who did not have their prescribed medicine for two days. Staff did not always have clear guidance when administering medicines prescribed 'as required.' The systems for stock control had been improved, following an incident whereby a bottle of pain-relieving medicine could not be found.

There were systems in place to assess and monitor the quality and safety of the service. However, not all shortfalls found during the inspection had been identified. Action plans regarding other areas were in place and being worked through. It was recognised the manager needed time to embed these changes.

Staff had received training in safeguarding and knew how to recognise potential signs of abuse. Risks to people's wellbeing such as falling and nutrition, had been assessed with measures taken to improve safety. Overall, safe recruitment practice was being followed.

People and their relatives knew how to raise a concern or formal complaint. The manager believed empowering people was important, so had reintroduced meetings for people to give their views.

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 requires improvement (published 18 September 2021)

At our last inspection we recommended that the provider sought guidance on their quality assurance systems to ensure they were submitting all legal notifications as required. At this inspection we found systems were in place to document and report any accidents and incidents appropriately.

Why we inspected
The inspection was prompted in part due to concerns received about people's care, inadequate staffing and management. A decision was made for us to inspect and examine those risks.

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, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We found evidence during this inspection that people were at risk of harm from the concerns raised with us, and those identified during the inspection. Please see the safe, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Wingfield on our website at www.cqc.org.uk.

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 safe care and treatment, person-centred care and 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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Wingfield

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

Service and service type
The Wingfield 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. The Wingfield is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 not a registered manager in post. The manager was newly appointed and in the process of registering with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 22 June 2022 and ended on 20 July 2022. We visited the location's service 22 and 23 June 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and 11 relatives about their experience of the care provided. We spoke with 13 members of staff, including the manager, regional director, nurses, care staff and housekeeping and catering staff. We reviewed a range of records. This included seven care plans and multiple medication records. We looked at three staff files in relation to recruitment and staff support. A variety of records relating to the management of the service including auditing, were reviewed.

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 changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were not enough staff to meet people's needs. This was also identified at the last inspection in July 2021.
- Staff were not always monitoring people's whereabouts, which impacted on safety and the risk of an altercation. For example, two people consistently walked around the home and went into other people's rooms. One person was sitting in another person's armchair, whilst they were in still in bed. A staff member said they often did this, and when they got tired, they could be found in other people's beds. A relative told us this had happened to their family member.
- At lunchtime in Memory Lane, it was hot and the atmosphere was busy. All staff were supporting people, but call bells were ringing.
- One person was in the corridor outside the dining room, unstable on their feet and asking for help. At the same time, a person had finished their meal but was fingering bread and marmalade and rubbing it into the tablecloth. Bits were falling on to their clothing and their hands were covered and sticky. There were no staff in the dining room to assist people, which impacted on safety and dignity.
- People, their relatives and some staff told us there were not enough staff. One person told us they had to wait to get up and go to bed, and often sat in soiled clothing due to their incontinence and lack of staff to assist them. A relative told us, "There aren't enough staff, for example, if [hostess name] isn't here, there's no morning coffee or trolley rounds." Another relative said, "They are understaffed. It does impact on care. You can see that because the ladies, who need a lot of help, complain they're left waiting a long time. They get upset".
- The manager told us there had been a high turnover of staff, which had impacted on staffing. They said consideration was being given to further recruitment and staff retention, to help improve the situation.

Failing to ensure there were sufficient skilled and experienced staff on duty was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, a senior manager told us a receptionist would be deployed at The Lodge, and there would be an increase in the number of hours allocated to ancillary staff. This was intended to develop the whole home approach to staffing, to enable care staff to solely concentrate on supporting people.
- Records demonstrated safe recruitment processes were followed.

Preventing and controlling infection

- Systems in place to prevent and control infection were not always effective.
- Staff did not wear their personal protective equipment safely. Masks were consistently worn below the

nose and some staff removed them completely when speaking to people. One relative confirmed this. They told us, "The staff are variable with their PPE, some wear masks, some don't. Quite a few take their masks down to speak."
● There were staff who were wearing nail varnish, bracelets and stoned rings. All such items could harbour bacteria and should not be worn when supporting people.
● On the first-floor dining room of Memory Lane, a member of staff was looking for a clothes protector for a person to wear. They could not find one in the dresser, so took one which was hanging over the back of a chair. This had already been used by someone else.
● The kitchenette at The Lodge was not clean. There was debris on the floor and over the walls, and limescale around the tap and sink. There were brown drip marks over the cups in the cupboard and staining to the plastic beakers. There were cobwebs in a person's room and debris in the passenger lift, also at The Lodge.
● There was a shortage of housekeeping staff due to vacancies and sickness. Due to this, housekeeping staff often worked on their own and then could not cover all required areas or complete regular deep cleaning. They said there were days when there was not a housekeeper on a particular floor. Any cleaning was then left to the following day.

Failing to ensure there were safe systems in place to prevent and control infection was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff took part in twice weekly testing for COVID-19 as per government guidance, and had completed infection control training.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to help protect people from the risk of abuse.
● The organisation had clear safeguarding policies and procedures in place.
● Staff had received training in safeguarding, which was deemed mandatory by the provider. Staff knew how to recognise and report signs of abuse, and said they would raise any concerns about poor practice.
● A record of accidents and incidents was maintained. Senior managers had access to this information, so could monitor appropriate action was being taken to minimise a reoccurrence.
● People told us they felt safe, although one person said the attitude of some night staff was not so good. They said, "They tell me "We've only just changed your pad", but I can't help that, as I've got no control over my bladder or bowels." The person was reluctant to use their call bell to ask for help. Other views were, "I feel very safe, as everybody likes everybody, all the staff are so nice" and, "I feel [family member] is safe, because we can talk to the staff if we've got any worries."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's health had been identified and acted upon to promote safety.
● There were risk assessments for example, related to skin integrity, falling, malnutrition and mobility. Actions to reduce these risks included specific care interventions and the use of equipment such as pressure mats. These mats alerted staff when a person attempted to get up from their chair or bed, minimising the risk of them falling.
● Mattresses to minimise the risk of skin damage were on the correct settings and staff used equipment, such as a hoist, safely.
● People and their relatives told us risks were generally well managed. They said staff walked with some people, and there were pressure mats in situ. One person however, told us staff did not always take into account their food allergies. This was raised with the manager.

Using medicines safely

● People's medicines were not always safely managed.

● One person had not received two doses of their prescribed medication to manage their health condition, because there was not any available. The manager told us there had been issues with some supplies, and this was being addressed through the GP and pharmacy.

● Some people were prescribed medicines on an 'as required' basis. Guidance to ensure staff administered these medicines as prescribed, was inconsistent. For example, there was not always information about when or why people had the medicines, or the signs which indicated they needed to be given. This particularly applied to medicines people had been prescribed for anxiety.

● Staff did not always document the reasons for administering pain relief on an 'as required basis' or if it helped the person. This did not enable effective monitoring of the person's pain or the medicine. For example, one person had been given pain relief 15 times in a period of just over two weeks, but the reason and outcome had only been recorded three times.

● The temperature of the rooms and refrigerators, where medicines were stored, was monitored. However, staff had recorded the temperature of the refrigerator in The Lodge, as being in range. This was inaccurate. The information did not show the high temperatures had been escalated as a concern. Two other refrigerators were maintained at a safe temperature.

● Time specific medicines were administered on time, and staff gave assistance to ensure people took their medicines, in a way that met their needs. These preferences were documented in people's care plans.

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. Any conditions related to DoLS authorisations were being met.

● Consent to care had been sought in line with guidance.

● People's capacity had been assessed in terms of living at the home, and the use of equipment.

● Some people were having their medicines administered covertly. This is when medicines are disguised in food or drink, without the person's consent. There were documents in place to show how the decision to administer this way had been reached, including input from the prescribing GP and pharmacist.

Visiting in care homes

● People were able to receive regular visitors, both in their room and communal areas, following the relaxation of government guidance. Relatives told us they valued being able to visit their family member, as and when they wanted to.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

- People did not always receive personalised care, which met their individual needs.
- People gave us variable feedback about their care. One person said, "I keep my own routine, I like to stay up late and sleep in later in the morning and that's ok, I can do that." Another person said, "I usually get my wash anything from 10 o'clock onwards, I'd like it earlier, but I have to wait my turn".
- One person was asleep, and a staff member woke them to assist with their mouthcare. The staff member did not explain what they were going to do and started without consent. This clearly caused the person distress and they shouted at the staff member. The staff member left the room without apologising. Another staff member told a person to have a drink. The person did not want this and responded by loudly shouting "No." The staff member replied by saying "Ok, ok, don't throw it at me."
- One person was in the lounge and called 'nurse' quietly. They did this twice and began to get upset as they thought everyone was ignoring them. They asked, "What shall I do now?" and we advised them to ring the bell, which they did. An agency staff member in the room did not ask if anyone needed help. Another staff member asked who was ringing, but the person did not hear them. Staff did not ask people individually to identify who needed help. We therefore intervened and alerted the staff member. A similar situation occurred later in the afternoon. This did not show an understanding of the person's needs.
- At 3pm, fluid monitoring records showed some people had not had anything to drink all day. Staff told us people had received drinks, but they had not completed the records. They said they would do so later, when they had the chance. One staff member told us the information was all in their head. However, delayed recording did not ensure accurate monitoring. This increased the risk of the person being thirsty or becoming dehydrated. Another staff member confirmed this and said, "Now we've got them [daily records] in the office, it's not up to date, and staff forget to fill them in."
- There were no care plans in place to help staff support people with distressed behaviours. Triggers to such behaviours, or measures to minimise the distress experienced had not been identified. This did not ensure people were supported in a consistent way, to promote their wellbeing.
- Records showing the monitoring of people's support lacked clarity. For example, within food monitoring records, staff had documented entries such as, 'Sandwiches – all' and, 'Minced meal and pud. Eaten.' This did not enable clear analysis, to demonstrate people had received a nutritionally balanced diet.
- Although oral care assessments were filled in, not all staff were confident when discussing how they managed people's oral health. One staff member told us people without teeth or dentures used mouthwash to keep their mouths clean. However, the person had a toothbrush and toothpaste in their bathroom. The staff member then told us they would use that instead and would "brush gently."
- Not all care plans gave clear information about people's individual preferences. This included the times people liked to get up or go to bed, whether men preferred a wet or dry shave or people's preferred choice of

clothing. Not all people had a completed 'About me' document in place.
● Daily records were not person-centred, and some terminology was disrespectful and did not demonstrate an understanding of the person's needs. For example, specific comments included "[Name] has been vocal. Let all [their] needs and wants known" and, "[Person] was not nice to the carers, was verbally rude." Another record stated, "Person sat in the chair all night. Pads changed. No concerns." Some staff used terminology when speaking to people, which was not appropriate. This included "Good lady," "My lovely" and "My love."
● There were various concerns about people's clothing being lost whilst being laundered. One relative said, "The laundry is a problem, clothes are getting lost all the time, T-shirts, socks etc." They told us as a result, their relative was often wearing other people's clothes. Another relative told us their relative was also known to have been seen in other people's clothes.

Failing to ensure people's care was appropriate and met their needs and preferences, was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to access healthcare as needed, although one person told us they needed to see a dentist, as they had a broken tooth. We informed the registered manager of this, and they said they would arrange an appointment. People received appointments with health care professionals as required. Records of these appointments were maintained.
● There were informative care plans in place regarding healthcare. For example, plans for people with diabetes listed signs and symptoms of high and low blood sugar, and the steps staff should take if either of these occurred.

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 were not always supported to receive information in a way that met their needs.
● Two relatives told us staff did not always help their family member put their hearing aids in, which restricted communication. One of these relative told us, "We've also found them in with no batteries, and once the battery had been jammed in the wrong way around, so I had to take them to [a company] who kindly helped me remove it." The manager told us they would investigate these concerns and arrange training for staff as needed.
● The manager told us the organisation had a range of resources, to help meet people's communication needs. This included large font formats, or language translating.

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
● Social activity was in the process of being developed, as shortfalls had been identified.
● People and their relatives told us there was not enough to do in the home. One person told us, "This music session and residents meeting held today [Wednesday], is the first thing this week. I get extremely bored and just go to my room to watch television." A relative told us, "They seem to spend a lot of time sat in front of the TV, there's no stimulation. What's on the activities notice board often isn't going on, as far as I can see." Another relative told us they had been informed of the sensory room, but it was usually locked, or used as a 'junk' room.
● Two activity staff had recently been employed. They were building relationships with people and

beginning to find out their interests, so activities could be better planned.
● A singer and the music therapist employed by the organisation provided entertainment and there was a PAT (Pets and Therapy) dog visiting. People appeared to enjoy and joined in with these activities.
● The manager told us local schoolchildren would soon be returning to visit people and undertake various activities with them. This had stopped temporarily due to the pandemic. A summer fete was being organised to support a local charity.

Improving care quality in response to complaints or concerns
● People and their relatives knew how to make a complaint.
● People told us they would speak to staff if they were not happy about the service. One person told us, "I spoke to [staff member] about being left in the chair until half past ten. She listened, and last night they came in at 9 o'clock and said, 'you're going into bed now'." Another person told us they would not complain, but saw a member of staff and said, "Ah, she's my armour this one is, she sees I'm alright".
● Relatives told us they had raised concerns, but had not made a formal complaint. They said action had generally been taken and concerns were resolved, yet this was sometimes inconsistent.
● The manager told us they had an open-door policy and aimed to be approachable so any concerns could be raised at an early stage.
● The organisation had a clear complaint procedure in place, and a record of complaints was in place.

End of life care and support
● The service was able to support people at the end of their lives. However, no one was receiving this type of care at the time of the inspection.
● People's preferences regarding admission to hospital if very unwell, and resuscitation, were detailed in their care plans.
● Two relatives told us they had been involved in their family member's end of life care planning. One relative said, "We've discussed what would happen if [family member] were to become unwell in the future, and if they should stay here or go to hospital. We had a good discussion about it with [staff name], and decided we'd only want hospital care if it was medically necessary, otherwise we'd rather keep them here."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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; 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

- There had been period of instability, caused by inconsistent management and oversight. This had impacted on staff support, communication and the overall quality of the service.
- A new manager started employment in June 2022 and was in the process of registering with CQC to become the registered manager. They said the service was on a journey, and whilst improvements had been made, they recognised there was more to do.
- A range of audits had been completed in line with the organisation's quality monitoring schedule. The audits had identified various shortfalls, and action plans were in place to address required changes. It was recognised the manager required time to address the shortfalls and embed any changes in practice.
- Some shortfalls found during this inspection, had not been identified. For example, there was inadequate monitoring of people's support, and care plans were not in place to help support staff to manage any distressed behaviours people displayed. In addition, it had not been noted some staff were wearing jewellery and nail varnish, or that the kitchenette and passenger lift at The Lodge, were not clean.
- Management did not take immediate action, to ensure staff wore their masks correctly during the inspection. Such shortfalls were seen on both days, with the majority of staff.
- The impact of staffing shortages, and feedback from people, relatives and staff about inadequate staffing, had not been recognised or fully addressed. Such feedback included people having to wait to use the toilet, being in soiled clothing and not being able to get up or go to bed when they wanted.

Failing to ensure effective quality monitoring systems were in place was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager said they walked around the home throughout the day to monitor practice and build relationships. They said they also worked various shifts alongside staff and liked to lead by example.
- The manager told us the home's admission policy was being carefully considered to aid the stability of the home. They said they were not prepared to accept people with very high care needs, due to the work and additional pressure on staff this caused.
- Aspects of the service, such as auditing, accidents, incidents and complaints, were held electronically. This meant the information could be seen, checked and monitored by senior managers to give further oversight.

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

● The service has had a period of management changes, as there had been three different managers in quick succession. This created a period of instability, and inconsistent leadership, which negatively impacted on people, their relatives and staff.

● The manager told us the culture of the home had changed significantly since their appointment, and morale was much improved. They said they were looking to empower staff and give accountability back to them. They had the vision of the home being fully staffed and an outstanding rating from CQC.

● Values adopted by the organisation, were being revisited with the staff team. Small cards were being developed for staff to carry. These would contain reminders of key values such as respect integrity and responsibility.

● Relatives told us the home was relaxed, friendly and open, with a positive atmosphere. One relative said "It's a good atmosphere, it feels relaxed, the staff always speak and stay in touch if anything happens. Communication is very good. We know one or two of them really well."

● There was positive feedback about the staff. One relative told us, "The staff are perfect. They work their socks off. The care is good, as they make sure it is." Another relative said, "The staff are lovely. They work so hard, they don't stop. There are a few that [family member] and I are really fond off."

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

● The manager told us involving and empowering others was important to them, and something they wanted to develop.

● Meetings with people who used the service and their relatives, had been reinstated. The manager said one person had been nominated as an ambassador and would raise views on behalf of others. The person however was not aware of this.

● The heads of department met with the manager on a daily basis to discuss the day's events and those people who were unwell. Handover meetings were held with staff, at the start of each shift to keep them up to date with people's needs.

● Relatives were encouraged to give their views about the service by completing an annual survey. There was a suggestion box, and relatives could leave a review on a well-known electronic care home reviewing site.

Continuous learning and improving care

● The new manager was focused on stabilising the service and improving practice.

● Action plans had been developed and were being implemented. The manager told us recruiting staff was a priority, and staff retention was being considered. They said this would lessen the use of agency staff, to ensure better consistency.

● The manager told us they were looking to introduce champions of various areas. This would enable specialisms in the staff team to be developed and their knowledge to be disseminated within the staff team.

● There was feedback from people's relatives and staff, that the service was improving. One relative told us, "We're going in the right direction. I just hope it continues." A member of staff told us, "Things are getting better, we're building a team and shaping new staff."

● One person had confidence in the new manager. They told us, "We've just had the residents' meeting and it was good. I felt [the manager] listened. The same issues came up as last time. Nothing had really been done from last time on any of the points we brought up, but hopefully things will start to change in the right direction."

● Relatives told us a better environment was being developed, as decoration and new furniture was taking place. One relative told us communal areas were now much brighter, although they hoped their family

member's room would also be refurbished.

Working in partnership with others

● The manager was developing working relationships with other professionals. This included commissioning, brokerage and other departments within the organisation.

● People were enabled to access services including the GP, optician and podiatrist, and specialist nurses related to their health conditions.

● The manager met other registered managers within the organisation every month. This enabled ideas to be discussed and learning to be shared across all services. They said a buddy system was in operation, which enabled close working with others.

● The manager was complimentary about the support they received from senior managers. They said they met the regional manager on a regular basis and could contact them at any time as needed.

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 9 HSCA RA Regulations 2014 Person-centred care Care planning did not ensure people's needs and preferences were met effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to prevent and control the risk of infection were not effective. Regulation 12 (1)(2)(8)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the service were not effective. Regulation 17 (1)(2)(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to meet people's needs safely and effectively. Regulation 18 (1)