Almondsbury Care Limited

Ferns Nursing Home

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Ferns Nursing Home is a nursing home in the town of Yeovil. They are registered to provide personal and nursing care for up to 39 people. At the time of the inspection 21 people were living in the home.

People's experience of using this service and what we found
This inspection was over two days. On the first day we visited there were not always enough staff on duty to meet people's needs in a timely and appropriate way. Staff were not responding to call bells promptly which placed people at risk of not receiving care when they needed it.

Most people were being nursed in bed when they did not have a physical need or didn't choose to stay in bed. A lot of these people required support with their meals and had to wait for assistance and their meals were going cold. Staff explained it took time to assist some people with meals as they could not be rushed.

People were not always regularly repositioned to ensure their comfort, and this could pose a risk to their skin integrity.

Risks to people were not being managed in relation to their nutrition and fluid intake.

People were placed at risk of cross infections because staff had poor infection control practices.

Although staff had received training regarding infection control, some staff were observed carrying soiled laundry around the home.

Cleaning was not taking place regularly around the home and in the kitchen.

The provider's quality monitoring processes had not identified these concerns.

We raised these concerns at the end of the first day with the provider's management team. They told us they would develop an action plan and work with the manager to implement it.

On the second day of the inspection, we observed improvements. People had been and were being assessed regarding having the opportunity to get up. During our visit nine people were enjoying time sat out in their rooms or in the communal areas.

People were having their call bells responded to promptly by staff and the management team. The provider was looking to add a device to the call bell system to be able to regularly audit call bell response times

Staff were seen wearing PPE and no poor practice was observed in relation to infection control. Cleaning schedules had been replaced and cleaning was taking place regularly.

People's mealtime experience was improved. People were being shown sample plates of the menu, there were personalised individual menu cards on each person's tray and new crockery and glasses had been purchased. We made a recommendation that the provider continue to review people's mealtime experience in line with appropriate good practice guidance

Improvements had been made to improve the quality and variety of the food offered to people. A new head cook had been recruited and a new four-week menu was being trialled.

Staff were using the provider's new monitoring charts, for food and fluid and repositioning. New improved guidance about people's individual needs was made available to staff in different places. This ensured they had clear up to date information about people's individual needs.

Care plans were being transferred to the provider's new care plan paperwork. In the meantime, staff had access to the old care system as well to ensure they had information about people's needs.
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 manager and management team were working with the staff team to improve the culture at the home. People said they were supported by staff who were kind and respectful towards them. On the whole staff interactions with people were respectful. However, on the first day of our inspection staff were not always knocking on doors before they entered people's rooms. Improvements were seen on the second day as all staff were seen to knock on people's doors.

Staff monitored people's on-going health conditions and made sure they had access to the local GP's and other healthcare services as needed. Each week a healthcare team connected to the GP surgery visited the home and reviewed all of the people there and then met with the GP.

Improvements were needed in medicine management at the home. We made a recommendation that the provider ensure medicine management at the home was in line with the National Institute for Health and Care Excellence (NICE) guidance 'Managing medicines in care homes.'

At the beginning of the inspection it was not clear staff were always recruited safely. The management team told us they had completed an audit of staff files and identified where there were gaps. By the end of the inspection we were assured recruitment checks had been completed.

There was not a robust induction programme in place to evidence new members of staff had completed an induction which ensured their competency for their role. A new induction workbook was implemented, and six staff had started using this induction workbook by the second day of the inspection.

People were cared for by competent staff who had received training to safely care for them.

All staff had received a supervision and told us they felt supported. One staff member told us how they had been supervising a small team and how it was effective.

The provider had taken action to ensure people were protected from risks associated with the building because improvements had been made in the testing and servicing of equipment.

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 inadequate (published 8 December 2021). 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 improvements were being made, however the provider was still in breach of regulations.

This service has been in Special Measures since May 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate in well led or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced responsive inspection of this service on 6,7 and 13 October 2021. We identified three continuing breaches in relation to safe care and treatment, staffing and governance. We issued a requirement for regulations 12 and 18 and a warning notice for the breach of Regulation 17.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions, Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Follow up
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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ferns 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 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
Three inspectors and an Expert by Experience undertook this inspection. 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
Ferns Nursing Home 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. Ferns Nursing Home is a care home with nursing care. The Care Quality Commission (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 CQC 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 the inspection there was not a manager registered with CQC at the service. A new manager had been appointed and told us they would be making an application to CQC to become the registered manager.

Notice of inspection

This inspection was unannounced.

What we did before the 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. The provider did implement a service improvement plan which they regularly reviewed and sent to CQC to demonstrate the improvements being put in place.

Since May 2021 Somerset County Council and Somerset Clinical Commissioning Group (SCCG) have suspended any new placements at The Ferns. We have received reports of visits made by the local authority and SCCG about the care provision at the home. We have kept in touch with the local authority quality team and SCCG throughout this time.

We used all this information to plan our inspection.

During the inspection
During our visit to the home we observed the care and support people received. We spoke with six people about their experience of the care provided. We visited everybody in their rooms as most people were being nursed in bed or sat in a chair. Only a few people were able to express their views about the service, so we observed the care they were receiving. We also spoke with five relatives and a visiting GP.

We spoke with the new manager, clinical lead/deputy manager, head of care, four care staff, a laundry worker, housekeeper, two assistants and two cooks. We also spoke with two nurses who were from a local agency working at the home.

On the second day of the inspection we met the new clinical lead/deputy manager on her first day in her new position at the home.

We also spoke with the provider's nominated individual, group quality and compliance manager, regional manager and a peripatetic manager.

We reviewed six staff files in relation to recruitment and staff supervision, five people's care records, and medicines end to end process. A variety of records relating to the management of the service, including policies and procedures, maintenance records, staff rotas, fire documents and external servicing records, training matrix and meeting minutes were reviewed.

After the first day of the inspection the provider produced an action plan to address the concerns we had identified and areas where they had recognised needed to be addressed. They sent this action plan to CQC during this inspection, so it has been included in this inspection.

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 for this key question 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

At our last inspection, the provider had failed to ensure people's care plans had current and up to date information relating to their individual needs. Although improvements had been made there were other concerns identified at this inspection and the provider was still in breach of Regulation 12

●Risks to people were not monitored effectively. Where people were identified as being at risk of not having enough to drink, fluid charts were in place to reduce the risk. Staff had not always recorded the amount people had drunk and the charts had not identified targets to aim for. This meant staff could not accurately monitor people's intake and they were at risk of not getting enough to drink.
●Where people were identified at risk and could not alert staff if they required support, hourly checks were in place. However, we observed there were gaps in these records. For example, one person's hourly check record, identified gaps on three consecutive days. This meant people were at risk of harm as checks on their safety were not taking place as required.
●Some people required regular repositioning to avoid developing pressure damage to their skin. Instructions to staff were not always clear about how often people required this support. Records showed the intervals for repositioning one person varied greatly. For example, on occasion the person was repositioned two or three hourly. However, there were occasions where records showed the person was not repositioned for five or six hours.
● Risks to people had been identified in care plans and there were risk assessments to inform staff of what action to take to reduce risks to people. For example, one person needed support to cut their food up to eat their meal. The person's care plan clearly identified the person was at risk of not eating if their food was not cut up. We observed the person struggling to cut their food, so did not eat it. We discussed our concerns with the manager.

We found no evidence that people had been harmed however this is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● By the second day the provider's management team had responded quickly to rectify these concerns. New monitoring charts were in place, each person had a fluid target and the night nurses were calculating people's intake. They were recording people's intake on the handover sheet, which was given to all staff providing care, so they were informed where there were concerns. This meant people were getting the right

amount of fluids to meet their needs.
●We saw significant improvement in the amount of checks on people being undertaken by staff. We discussed with the quality manager there were still gaps on people's monitoring charts. They confirmed, it was a new system and they were working with staff to further improve their recording and the new system would need time to embed.
●On the second day, staff had clear guidance about people's individual needs. The management team improved information to guide staff about people's needs. Printed handover sheets which identified people's personal care, mobility, choking risk and diet and fluids needs were given to staff daily, so they had clear up to date guidance. A brightly coloured pictorial/facts document had been placed in each person's wardrobe giving new staff a miniature snapshot of people and their requirements. This was useful for agency staff and new staff. A coloured dot system had been introduced where dots were placed on people's personalised laminated sheet on their doors. Each colour depicted people's needs. For example, if they were at risk of falls a pink dot or required prompting a yellow dot.
●Pressure mattress settings were checked against each person's personal requirements recorded on a key fob on the person's mattress during each reposition to ensure they were still set at the correct setting. This meant people were protected from the risk of developing pressure damage to their skin.
●The management team had good oversight of people's weight gain and loss and where they identified people were losing weight, appropriate action was taken. People had their weight checked either weekly or monthly depending on their risk. The majority of people had gained weight at the home in 2022.
●The provider had taken action to ensure people were protected from risks associated with the building because improvements had been made in the testing and servicing of equipment. There was a system in place to ensure health and safety checks, such as testing water temperatures and fire detecting equipment, were carried out regularly. Where concerns had been identified with water temperatures action was taken to get this resolved and signage put up to advise people.

Preventing and controlling infection

At our last inspection, infection control procedures were not being following to ensure staff were wearing PPE as required in line with government guidance and laundry was being stored safely to prevent the spread of infections. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Concerns for people's wellbeing and risks relating to infection control were not robust. The clinical lead informed us there had been changes with staffing levels in regards the laundry and cleaning staff. We were informed the home was cleaned in line with the providers cleaning schedule each day. However, on the first day of the inspection there were gaps in the cleaning charts of up to three consecutive days where no cleaning had taken place at the service. A member of staff confirmed there were a number of days the service had not been cleaned as domestic staff were not on duty.
●Touch point charts identified staff were requested to 'wipe down touch points with anti bac wipes every two hours'. On the touch point chart week commencing 25 April 2022, three consecutive days had gaps of up to four hours. By the second day of the inspection improvements had been made and the management team were monitoring that cleaning was being undertaken as required.
● On the first day of the inspection the kitchen cleaning schedules were muddled, and it was not easy to establish that the appropriate level of cleaning was being undertaken. By the second day the management team had put in place a new cleaning record and updated their food standards folder.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Staff did not always follow good infection control practice although the providers training

matrix showed that 97% of staff had completed infection prevention and control training. On the first day of our inspection, staff were observed on three separate occasions carrying contaminated laundry through the home, without using the correct red bins provided by the provider to transport contaminated laundry

We have also signposted the provider to resources to develop their approach.

We found no evidence that people had been harmed however this is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 back into the service when they had been into hospital.
● 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's infection prevention and control policy was up to date.

We raised our concerns about the infection and preventions controls at Ferns Nursing Home with the management team at the end of the first day of our inspection. The provider sent us an action plan after the first day of the inspection telling us daily spot checks and audits were being completed by the management team until good practices were embedded. On the second day of the inspection we did not see any IPC concerns in relation to staff practice.

Visiting in care homes
The manager informed us they had an open door policy for visiting. Relatives we spoke with said they had been able to visit as they wanted.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient suitably qualified and experienced staff and that staff had appropriate training, supervision and an appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remains in breach of Regulation 18.

●There were not always enough staff on duty to meet people's needs. On the first day of the inspection people's needs were not always met in a timely and appropriate way. Throughout the first day of the inspection we heard call bells ringing for more than five minutes. The delay in answering call bells put people at risk of harm. People told us call bells were not responded to quickly. Comments included, "You can wait for the call bell to be answered, usually too long", "They try their best, but they are too busy" and "If I press the call bell they are so long that I will have had an accident by the time they get here."
●12 of the 20 people at the service required staff assistance or supervision at mealtimes according to the records provided to us. Several of these people remained in bed throughout the day, with staff delivering meals to them, and then returning to assist. This meant some people had to wait for assistance and meals were going cold. One person had been served both lunch and pudding at the same time. Ice-cream was served with pudding, and as the person was eating their lunch, the ice cream was melting. Staff explained it took time to assist some people with meals as they could not be rushed.
●The provider's management team had completed two dependency tools and assessed the staff level required at the home to meet people's needs. The tools had identified there were sufficient staff on duty.

The management team had increased the number of care staff on duty to seven in the morning and seven in the afternoon/evening because they felt this was needed. However, on the first day of the inspection people's needs were not being responded to promptly. Improvements were seen on the second day, but staff were being supported by the management team to respond to call bells.

The provider had failed to ensure there were sufficient staff at all times to meet people's needs.on duty This is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We fed back our concerns to the management team about call bells not being responded to promptly. On the second day of our visit call bells were being responded to within a couple of minutes. The quality manager told us they had been working with staff on call bell response times, they had also reminded senior staff of their responsibility to respond to call bells. They went on to say they had ordered a system that would enable them to undertake call bell audits to monitor staff response times.
●Staff confirmed staffing levels had improved and that they had time to deliver care and also have some social time with people chatting. On the second day a relative who visited regularly, told us, "Lately things have improved." They gave examples of the door being answered more promptly, the garden had been tidied, their relative's bedroom folder was in order and staff interaction with their relative had increased. They commented, "The staff are lovely, they are wonderful."
●At the beginning of the inspection it was not clear staff were always recruited safely. We requested two new members of staff recruitment files who were transferring from another of the providers services. We were informed the recruitment files were not in place at the home. We were told the provider's HR department undertook recruitment checks and the manager would request the recruitment paperwork. After the inspection the manager wrote to us to explain there had been a mistake and the documents we had requested were at the home in a different folder.
●We found there were some gaps in staff recruitment files. This included one with minor gaps in the employment history and one file did not have photo ID of the staff members employed. There was no evidence the provider had explored these gaps with staff prior to them starting work to ensure they were suitable to be employed working with people. We raised this with the management team and the nominated individual told us they had competed an audit of staff recruitment files as some staff had worked under the previous provider. The providers HR team were working to ensure all files contained the information they required. After the inspection we received confirmation that all of the staff files contained the required checks and documentation.
●The provider relied on agency staff to support the home whilst vacant posts were filled. One person said, "There are not enough staff, so they get agency staff. There are lots of agency staff." A relative told us, "The staffing is better now but we need to have the same agency staff not different ones every time." The manager said they tried to block book agency staff so they could have staff who knew the service well and provided consistency for people.
●There was an agency file in place, with profiles from the agency they worked for. There was not a process in place to show that checks had been completed on the information and training provided by the agency. By the second day improvements had been made. A new induction and information requirements form was in place for all agency staff to complete. This included, a health and safety induction and key information about the home and system used.

Using medicines safely
●Improvements were needed in medicine management at the home. People were at risk of not receiving their prescribed medicines. One person had not received their prescribed medicine for five days. This was due to a shortage of supply at the providing pharmacy. However, no action was taken by the service to seek

advice from the GP about an alternative treatment to ensure the person had their necessary medicines. The manager told us they had been having difficulties with the pharmacy providing the medicines and not being able to access some medicines. They were speaking with the GP surgery and pharmacy to try and find a solution to this concern.

●The supplying pharmacy had undertaken an inspection of the medicine management at the home on the 27 April 2022 and had identified some of the issues we found at this inspection. The management team were working on these areas, but they had not been completely addressed. For example, handwritten entries on Medicine administration records (MAR) had not been double signed to ensure accuracy.

●The recording of medicines prescribed as a variable dose did not state the exact does given. This meant monitoring the effectiveness of the medicines was challenging.

●The management of topical medicines, such as creams, needed to be improved. Records were unclear about the frequency of use of some creams, for example, stating "apply frequently to moisturise". However, the records did not specify what frequently meant. Records of applications showed the creams were applied just daily. We were not assured that topical medicines were being used consistently as prescribed.

●Registered nurses were responsible for the management of medicines within the service. However, competency checks were overdue, but these were being organised to ensure safe practice.

●Other aspects of medicines management were effective. For example, all medicines were stored safely and at the correct temperature, this included medicines that required additional secure storage. There were arrangements in place to ensure people who required time critical medicines received them at the agreed times.

●People were happy with how they received their medicines. One person said, "The times we get the medications are OK. Sometimes they leave my paracetamol for me to take when I am ready."

● There were protocols in place for administering PRN (as required) medicines.

● Medicines were audited regularly with action taken to follow up any areas for improvement.

We recommend that the provider ensure medicine management at the home is in line with the National Institute for Health and Care excellence (NICE) guidance 'Managing medicines in care homes.

Systems and processes to safeguard people from the risk of abuse

●People told us they felt safe at the home. Staff we spoke with understood how to identify and report safeguarding concerns. They were confident the manager would act on any concerns.

●Staff were aware of external organisations they could contact should they have concerns which had not been acted upon.

●The staff training matrix showed 91% compliance with staff completing safeguarding and protection of adults training.

●The new manager had identified that not all safeguarding concerns had been notified to the Care Quality Commission (CQC) by the previous manager as required. They had submitted numerous retrospective notifications to ensure CQC were informed. They said they were committed to demonstrating they were an open and transparent service.

Learning lessons when things go wrong

●On the first day of the inspection we found significant concerns at the home. The management team acted upon our concerns and put in place an action plan. They had made improvements by the second day of our visit. For example, this included, people were having an improved dining experience, improved communication with people, relatives and staff and improved oversight of people's dietary and fluid intake.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection in November 2021 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure there were sufficient suitably qualified and experienced staff and that staff had appropriate training, supervision and an appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvement at this inspection in relation to staff training, supervision and appraisals. However, there was not enough improvement made by having sufficient staff on duty to support people with their needs. Therefore, at this inspection the provider was still in breach of regulation 18

● A lot of work had been undertaken to ensure staff had undertaken training. Staff had completed 86% of the provider's mandatory training. This included, basic life support, fluids and nutrition, person centred care and record keeping. This was leading to better care for people.
●However, there was a delay in new staff receiving training necessary for them to work safely. A member of the domestic team employed for three weeks had not received any formal training or induction apart from one day shadowing another member of staff.
●We could not see there was a robust induction programme in place to evidence the new members of staff had completed an induction which ensured their competency for their role. We spoke with two members of staff who were on their induction, there was no formal process in place to support them. This meant new members of staff were not getting the time and support to ensure they had completed and understood their learning. After the inspection the manager sent us the providers new induction booklet and told us six staff were working through it.
●On the second day, the manager told us they had discussed with staff their areas of interest and the role of champions at the home. A board in the main entrance identified 12 champions roles, these included, infection control, tissue viability and end of life. The manager told us there would be bespoke training for each area and that champions would work with other champions at the providers other services.
●The manager had been working on a program of supervisions. They had drawn up a flow chart delegating senior staff to complete supervisions. All staff had received a supervision and told us they felt supported. One staff member told us how they had been supervising a small team and how it was effective.
●The manager told us they were having a policy of the month. Staff would receive these and then in group supervisions they would be discussed.

Supporting people to eat and drink enough to maintain a balanced diet
● People's feedback about the quality of food and choices on offer was mixed. Most people were happy, but

others wanted more improvement. People's comments included, "I can't stand the food! It is terrible. I have lost my appetite. Food is often served cold" and "It's alright; good most days. Not so good other days. We get plenty to eat." A relative said, "It is ok, not the best I would say".

●On the first day of the inspection people did not receive a good mealtime experience. Meals were served from a hatch from the kitchen, names of people living at the service were on the door and staff signed to say they had taken the person's meal. We asked one member of staff how they knew whose meal they were taking. They showed us the room number was written on the napkin which was also on the tray. We observed one person being supported to eat their meal, the staff member did not speak with the person or inform them what they were eating. This meant people were not receiving personalised support which encouraged them to eat a balanced diet.

●People were not being offered a nutritional alternative meal if they did not want the main meal. On the first day the alternative option to the roast pork meal was cheese on toast.

●Everybody at the home received their drinks in plastic cups and beakers. We did not see any rationale for this in people's care plans and there was no evidence this was people's choice.

●We discussed our concerns with the management team at the end of our first day. We saw improvements had been made by the second day, these included people being shown sample plates of the menu, personalised individual menu cards on each person's tray and new crockery and glasses had been purchased, although staff said people had chosen to continue to use the plastics cups. New coloured coasters were being used to guide staff about people's support needs with their drinks. For example, red coasters for people who required assistance and green for when they did not require assistance. We were also told that they had ordered new coloured trays with the same process regarding people's food.

●The management team were working to improve the quality and variety of the food offered. They had recruited a new cook and had implemented a new four-week menu which they were trialling. They had ensured people's food passports were in the kitchen and that required food temperature checks were completed.

We recommend the provider continue to review people's mealtime experience in line with appropriate good practice guidance.

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

●The provider was introducing a new paperwork format to record people's care needs and care plans. This transition was in progress. To ensure people's information was always available, staff had access to the old care records and new care folder while the transition took place. We looked at a nearly completed new care file and saw it reflected the person's needs. At the beginning of the file there was a clear care plan checklist, setting out the different areas of the folder and for staff to complete stating if the section had been completed. For example, admission assessment, rights, consent and capacity needs and drug therapies and medication needs.

●Staff regularly reviewed people's dependency assessments about personal care needs and activities of daily living. This made it clear if people's needs were changing and therefore care provided could be adjusted to meet their needs. This information would also enable the management team to assess the staff required at the home.

●Care plans identified people's assessed needs and their expected outcomes and were regularly reviewed. The manager was working with staff to ensure people and their relatives as appropriate were involved in developing and reviewing care plans.

●Since April 2022 people had their care needs reviewed on a regular basis using 'Resident of the day' (ROD) model. This included each day one person had their care records and risk assessments reviewed and they and/or their relatives were asked their views.

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

●The provider was only using the ground floor of the home. This was because there had been a restriction on admissions by the local authority. The provider's management team were in discussion with relatives and staff about what the first floor could be used for when it is reopened.

●People's rooms were personalised with their personal possessions and personal photographs.

●A lot of work had been completed by the provider during the two days of our inspection. This included making a new office for the manager in a more central easily accessible part of the home. Another area of the home had been adapted as a storeroom to store mobility equipment and PPE. This meant the home appeared tidier and less cluttered on the second day of our visit.

●The provider had decorators working at the home to undertake decorating as needed in people's rooms and in communal spaces. This was helping to provide a pleasant environment for people to live in.

●People had access to a large communal lounge area and an outside garden area. The management team said they had plans going forward to make the areas more accessible and usable for people.

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

●People lived in a home where there were always trained nurses available to monitor their health and well-being. Staff monitored people's on-going health conditions and made sure they had access to local GP's and other healthcare services as needed, such as speech and language therapy; podiatrist; occupational therapist and specialist nurses.

●Procedures were in place to share information with external health care professionals to support people with their ongoing care. We were told each Friday a healthcare team connected to the GP surgery visited the home and reviewed the needs of all the people there. They then met with the GP and the MDT (multidisciplinary team) to discuss people's needs. The GP told us this system was working well, they said, "It works well with the team coming in on Friday, there are less concerns being raised about actions being undertaken by the home." They did go on to say, their "Things are improving but there is still a way to go. Main concern is amount of people being nursed in bed."

●We discussed with the nominated individual and management team at the end of our first day, that 19 out of 21 people at the home were being nursed in bed. They told us this is an area of concern they had already identified at the home. They said they had been working to ensure people were being able to get up if they were able and or wanted to. The management team told us in the action plan they sent to us after the first day, that people had been referred to Occupational Therapy for assessment and they would be assessing people and, where needed, look at getting specialty chairs. On the second day of our visit nine people had chosen to sit out and four of these used the main communal room to have their lunch. One staff member told us they had seen improvements in people's presentation, with how much people were eating and some people were sleeping more soundly at night.

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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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We observed staff sought people's consent and involved them in day to day decisions about the care and support they received. For example, on the second day people were being asked where they wanted to spend their day.
- Staff had a good understanding of the mental capacity act and the importance of supporting people to make decisions and respecting those decisions. The providers training matrix showed 88% of staff had completed training about the MCA and DoLS.
- Care records showed people's capacity to make decisions had been assessed. Where people lacked capacity, relatives and/or professionals were consulted and involved in best interest decisions.
- Records showed consent was sought for a number of matters including consent for COVID-19 testing and consent for personal care. People also had an individual capacity care plan to guide staff about their individual understanding and needs.

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 inadequate. 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

At our last inspection we found the provider had failed to ensure the mitigation of risk to people and the quality of the service provision was identified and actioned through effective governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17

●On the first day of our inspection it was clear the providers quality monitoring processes were not robust and had not identified the shortfalls we found during the inspection.
●The providers monitoring system had not identified that risks to people were not being monitored effectively, regarding people's food and fluid needs, tissue viability and comfort needs
●They had not identified areas of concern we found in relation to infection control practices at the home. There was not consistent regular cleaning of the home, staff were not always following good infection control practices and kitchen cleaning was not being completed robustly.
●The management team had not taken action promptly to improve medicine management at the home.
●On the first day of the inspection we identified accurate, complete and contemporaneous care records were not always maintained. On the second day of the inspection there were improvements of staff recording on people's monitoring charts. However, people's daily diet and fluid records were not fully completed; and daily repositioning records had some gaps. This meant oversight of the quality and safety of people's care was not effective. We discussed with the quality manager that we had seen a significant improvement but there were still gaps on people's monitoring charts. They said, it was a new system and they were working with staff to improve their recording.

The provider had failed to ensure robust quality assurance systems were established and operated effectively to continually assess, monitor and improve the quality and safety provided. This is a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Since the last inspection there was a new manager at the home. They had worked at the home as a nurse since November 2021 and was promoted to the role of clinical lead in February 2022 and had taken over as the manager in March 2022. This was their first role as a manager, and they told us they would be putting in

an application with the Care Quality Commission (CQC) to become the registered manager. Staff expressed their confidence in the new manager. A staff member said, "The manager's door is always open…will pick staff up and follow through…"

●Relatives were positive about the new manager. Comments included, "(Manager) is very approachable", "Transparency and candour had been patchy in the past but getting better now" and "Management will talk to each other and to you. All that I have asked for has been addressed."

●The manager was supported by a deputy manager who was also the clinical lead, and a newly appointed nurse had been appointed to take on the role. The manager told us they were trying to recruit a team of nurses, so they were not reliant on agency nurses. They felt this would be better for teamwork, continuity and being able to delegate responsibilities. This was echoed by a relative who told us, "Continuity of nurses should provide the joined-up approach but that is more difficult if they are agency."

●Since the last inspection the provider had a new senior management team in place. This included a new nominated individual, group quality and compliance manager, regional manager and peripatetic manager. They all joined us during the inspection. They told us they had identified concerns at the home and had plans in place to improve the service. At the end of the first day we told them we were concerned about people's quality of care at the home and although they had plans for the future we were concerned with the present. The nominated individual told us they would develop an action plan and send to CQC, which they did, setting out how they were going to improve people's care experience. By the second day of the inspection we saw improvements had been made and were a work in progress.

●On the second day of our visit it was evident a lot of actions had been completed to improve the service. although these changes had not yet become embedded. The management team had worked with the manager and staff team to implement their changes. The quality manager told us it was work in progress and was pleased staff had been open to the changes and embraced them. The nominated individual said, "Staff are buzzing, really coming on board and have been brilliant working as a team."

●One staff member told us, "We have been crying out for help, now we have it. It has been mad, but it is so much better…Things are getting done." They listed the improvements they had seen. These included, the food, activities, documentation, people getting up, the manager's office being more accessible, the manager working alongside staff, feeling appreciated and teamwork.

●The provider was introducing new systems to ensure oversight of the safety and quality of the service was improving. This included a new electronic software governance program, a system to record accidents and incidents, audits and weekly performance reports. This meant the provider would have a clear oversight of how the home was performing and any issues developing.

●The nominated individual told us the providers quality/regional team would be visiting the home every week until they were assured, to monitor and assess the progress being made.

●A daily meeting each morning had been established for all the heads of department to discuss any changes and reflect on various issues and ensure any tasks were completed. This included any staff absences or accidents and incidents. Staff said this had improved communication among the teams. One staff member said, "We are feeling more confident, feel more appreciated…10 at 10 meetings are so much better."

●Staff attended a handover at the beginning of each shift. To ensure all staff had information about people's needs they all received a handover sheet at the beginning of their shift. The night nurses ensured the handover sheets were kept up to date and populated them each night with people's fluid intake the previous day. The manager and clinical lead also attended handover a couple of times each week to keep themselves informed and visible to the staff team.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

●The manager recognised the importance of improving communication with people and relatives. They

confirmed this was an area which required improvement and had been making calls to relatives. This was echoed by a relative who told us, "We used to have a relatives meeting which was very useful, but we have only had one meeting since Covid." The manager arranged both a relatives and residents meeting and told us going forward these would be happening regularly. They sent us the minutes of the first relatives meeting, which was well attended and informative. Minutes recorded, 'Family members present said how much they had seen the home change for the better over the last few weeks and wanted their appreciation passed on to the staff and to (manager) for all their hard work.'

●On the second day we were given a revised resident's handbook, which we were told would be shared with people and relatives. This had information about the new manager and direct contact details. It contained information about the service, complaints and identifying abuse.

●The provider sent out surveys to people, relatives and staff during the inspection. They had received 13 staff responses which were mainly positive with a couple of negative responses.

●Six people had responded to the survey. The management team had collated and were working to address, areas which required action. They had put a board in the main entrance to advise people with the heading, 'you said we did' which showed how they were addressing issues identified.

●Seven family, friends and advocates had responded to the survey. Responses had been collated with a clear action plan of actions taken in response to concerns raised. For example, "Every single day… lunch is the same…generally the staff have little idea what they're serving." The managements response, "Visual meals are now offered to all residents who are unable to make verbal choices, this has been in place for two weeks and is working well. Staff are informed of meals they are serving by the cook and kitchen assistant."

●To get feedback from people who were unable to communicate their views, the management team had introduced talking books for complaints, concerns and compliments, safeguarding, food and care surveys. This enable people who had difficulties communicating to be able to be informed and able to record their views.

●The manager held staff meetings to keep staff informed and to ask for their views to keep improving the service.

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

●The manager and management team were working with the staff team to change the culture at the home, so people received care that was person centred and promoted their independence.

●People said they were supported by staff who were kind and respectful towards them. People's comments included, "Staff are nice. They never rush me. I am happy with support from staff" and "Staff are very nice. I get to know them. They are very kind people". We could see that some staff had developed a strong rapport with people. Staff interactions with people were respectful. They used people's preferred names and there was gentle banter and laughter. When one person became distressed, staff were skilled at calming the person and distracting their attention to more positive things.

●We saw on the first day of our inspection staff were not always respectful to people and did not knock on doors before they entered people's rooms. We raised this with the management team and on the second day, we observed staff knocking on all doors before entering. One person told us, "The staff always knock on my door now." The provider had also introduced 'Do not disturb' signs on people's doors. This was so staff could change the sign to make others aware they were supporting people with personal care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The management team understood their responsibilities to be open, honest and apologise if things went wrong. For example, they had identified the previous manager had not submitted statutory notifications and had sent these in retrospectively.

●The provider's management team were very visible at the home and easily accessible to staff, people or relatives who wished to raise issues, share concerns or give compliments.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess and monitor the risks relating to the health safety and welfare of people and had failed to mitigate the risk of infection transmission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality monitoring systems were not effective and had not identified some poor quality and safety of care being provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff at all times to meet people's needs.