HC-One Oval Limited

Avon Court Care Home

Inspection report

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Date of inspection visit:
19 August 2020

Date of publication:
24 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Avon Court is a residential care home providing personal and nursing care for up to 60 people. At the time of this inspection 33 people were living at the home. People lived across two floors, the upper floor was for people living with a diagnosis of Dementia and ten intermediate care beds. These were short stay admissions to the service, for people who required time for rehabilitation following recent hospital admissions.

People's experience of using this service and what we found
Staff were knowledgeable about local safeguarding procedures and knew how to raise safeguarding concerns. However, we found that there was a failure to act on safeguarding concerns when these were raised to management. This was a breach of Regulation 13 Health and Social Care Act 2008 (HSCA) RA Regulations 2014 Safeguarding service users from abuse and improper treatment.

Risks to people's well-being and safety had been assessed and a risk assessment put in place. We saw however, there was not always clear guidance documented for staff on how to mitigate these risks. At this inspection the provider had made some improvements however, medicines were still not always being managed safely. This continues to be a breach of Regulation 12 HSCA RA Regulations 2014 Safe care and treatment.

Two notifications of alleged abuse had not been notified to CQC or managed appropriately. This is a breach of Regulation 18 (Registration) Regulations 2009 Notifications of other incidents.

The service had continued to complete regular quality monitoring of the service. A report of improvement actions was in place and updated as the service progressed. However, where things had been identified these were not always sustained or managed successfully to drive change. This is a continued breach of Regulation 17 HSCA RA Regulations 2014 Good governance.

Staff had mixed views on the culture of the home and their feelings of the staff working as a team. Most staff felt the registered manager was approachable and could see improvements to the service.

Care plans had been re-ordered to be clearer in the layout and finding specific information needed. Repositioning charts were being completed and we did not see any gaps in these. We saw some examples of things recorded in records that did not have further evidence of being followed up. We have made a recommendation that the provider reviews how to monitor recorded evidence.

The service had been successful in recruiting staff to the team to fill vacant positions. Staff told us there was enough staff to support people safely.

People had been supported to maintain contact with their family and friends. People had been receiving

more one to one activities during the pandemic. People and their relatives were aware of who the registered manager was and how to contact him. Relatives said he was responsive and available when needed.

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 5 December 2019). The service has now been rated Requires Improvement.

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 had been made and the provider was no longer in breach of Regulation 9 HSCA RA Regulations 2014 Person-centred care. However, the provider continued to be in breach of Regulations 12 HSCA RA Regulations 2014 Safe care and treatment and 17 HSCA RA Regulations 2014 Good governance. Two new breaches of regulation were identified, 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment and 18 (Registration) Regulations 2009 Notifications of other incidents. A recommendation was made around monitoring documentation to drive improvements.

The last rating for this service was requires improvement (published 5 December 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

This service has been in Special Measures since December 2019. During this inspection the provider demonstrated that some areas of improvements have been made. However further breaches of regulations have been identified and improvements were not always sustained. The service remains Inadequate in safe and will therefore remain in special measures at this time.

Why we inspected
This was a planned inspection based on the previous rating.

We carried out an unannounced comprehensive inspection of this service on 24 and 25 September 2019. Five breaches of legal requirements were found. We served three warning notices against the service. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We completed an unannounced targeted inspection on 24 January 2020 to follow up on the three warning notices served. The provider was found to have only met one of the three at that time.

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 of Safe, Responsive and Well-led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. We have found evidence that the provider needs to make improvement. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

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

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

hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, mitigating risks, medicine management, leadership and governance and failure to notify allegations of abuse at this inspection.

A positive condition has been applied to the provider's registration at this location in respect of the breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance. Requirement notices have been made for Regulations 13 Safeguarding service users from abuse and improper treatment and Registration Regulation 18 Notification of other incidents.

Follow up
We have held meetings with the provider following this inspection to discuss the concerns. We are continuing to meet with them to seek assurances that people are safe and necessary improvements are being made to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Requires improvement'. However, we are keeping the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Avon Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. This was a focused inspection to review the key questions of Safe, Responsive and Well-Led only. We did not inspect the other key questions at this time. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

Inspection team
The inspection was carried out by two inspectors and one medicines inspector.

Service and service type
Avon Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provide

Notice of inspection
We gave short notice of the inspection. This was due to the current pandemic to allow the service time to implement any additional infection control measures for the visit.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with twelve members of staff including, the registered manager and area quality director.

We reviewed a range of records. This included eight people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Staff were knowledgeable about local safeguarding procedures and knew how to raise safeguarding concerns. However, we found that there was a failure to act on safeguarding concerns when these were raised to management.
- Staff we spoke with gave mixed feedback about concerns being acted upon. Some staff felt confident that concerns they raised would be acted on accordingly saying, "I'm confident he's [registered manager] efficient and would take things seriously." Other staff however gave examples of safeguarding issues they had raised previously that they felt had not been investigated appropriately and had not received support for.
- During the course of this inspection we received two whistle-blowing concerns. These raised concerns around issues including rough handling shown by a staff member, a lack of menu choices, incorrect manual handling and a culture of bullying within the staff team. One staff told us, "I don't think staff are always respectful. They don't tell people before they move them. They don't treat people with dementia nicely and it's sad to see, I have so much respect for elderly."
- An allegation of witnessed verbal and emotional abuse to a person living at the service by a staff member was raised to us following this inspection. We immediately raised this with the provider to investigate and informed the Local Authority safeguarding team. This had not been reported to the Care Quality Commission despite the registered manager being informed and the appropriate action had not been taken. This had meant the person and others had been left at increased risk of further abuse. The provider has now informed us that the allegation was substantiated and the provider is following their HR processes to take the appropriate action with the staff concerned.
- It was hard for relatives to give feedback as they had not been into the service since March 2020. One relative told us, "I don't think I have any concerns, we haven't been able to see [person] since early March. Normally we would be able to face time, [person] can't see us but we speak to them every day, on the whole they seem fine and they would talk if things weren't fine."

This was a failure to protect people from abuse and improper treatment and is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has investigated the whistle-blowing concerns and sent a report detailing their findings and the actions they will be taking as a result.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's well-being and safety had been assessed and a risk assessment put in place. We saw however, there was not always clear guidance documented for staff on how to mitigate these risks.

● For example, we saw one person's risk assessment identified a need for four staff, however there was no guidance on how these four staff should safely support this person. Another risk assessment identified that a person required a hoist however did not specify which hoist or sling they required.
● One person who was at high risk of falls and had experienced eight falls in two months and had a sensor mat in place and regular checks from staff. The assessment stated they often moved this mat. There were no details about other measures considered in light of moving this sensor mat and considering the number of falls experienced. The registered manager told us they were considering an infra-red sensor but this had not been recorded anywhere. Following the inspection, we requested this person's fall plan and saw an entry had been added after the inspection which recorded a lot more detail about the management of the falls that had not been previously available.
● One person had experienced a choking incident in July 2020. Their assessments dated June 2020 did not provide clear guidance for staff and was confusing. For example, it stated the person had no difficulty in swallowing. It then recorded however that this person had needed previous urgent attention when choking during eating and drinking and needed assistance with food cutting up or preparing prior to consuming. The support was documented as none. The word occasionally had been written and crossed out before recording needs assistance cutting foods up into bite size pieces. The word 'full' had been added above assistance. It also recorded no concerns and the person did not need to be monitored. A second care plan was sent and showed this had only been updated on the day of this inspection. This inconsistent recording was not safe to prevent the risk of potential harm to people.
● Incidents and accidents were recorded on the provider's electronic system and printed off. We reviewed these since our last inspection and saw that where people had fallen some actions were recorded such as post fall observations and updating family members.
● We found that there was not always details on measures implemented as a result, either in care plans or as part of the actions on the incident forms. For example, considerations to people's environment or reflective learning or actions taken with staff.
● For the person that had experienced a choking incident in July, a root cause analysis had been completed. This determined that the person had choked because of staff error. The care plan stated they needed their food cut up and on this occasion this had not been followed and the person had choked and needed support. This had not been reported to the Care Quality Commission and there was a lack of evidence recorded of the actions taken or a review of their care plan. The management team informed us this had been an oversight on their part.

This demonstrates a failure to mitigate risk and is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw that for people at risk of pressure damage, skin integrity care plans were in place. These recorded the support people required to change their position and the frequency of this.
● At the last inspection some people had stress and distress care plans in place for times when they presented with behaviours that placed them, staff and others at risk of harm. At this inspection the registered manager told us there was no one in the service with these behaviours or who had a stress or distress care plan available to view.

Using medicines safely
At our last inspection the provider had continued to not manage medicines safely for people and had not met the Warning Notice served. An action plan was sent by the provider to detail how they would address these outstanding concerns. At this inspection the provider had made some improvements however, medicines were still not always being managed safely. The provider remains in breach of Regulation 12 for the fourth consecutive time. The Care Quality Commission is considering the action that will be taken in

response.

● Some people were prescribed medicines to be taken on when required (PRN) basis. Guidance in the form of PRN protocols were not always in place to help staff give these medicines consistently.
● During the last inspection we had found care plans for medicines did not always have the necessary information related to prescribed medicines. The provider had made some improvements, however, medicine care plans still did not always have information about people's medicines prescribed to manage seizures. For example, information to guide staff on how to monitor and what actions to take if a person had experienced a seizure.
● The staff had hand written some medicine administration records (MAR). However, staff members had not checked, signed and dated some of the hand-written MARs. This meant there was a risk if there was an error it would not be identified.
● Internal medicine audits carried out identified gaps related to medicines management. However, the actions related to PRN Protocols and care were not completed.
Following this inspection we requested a further action plan from the provider to respond to these specific concerns.

This continues to demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a medicine policy in place. The provider had reissued the policy to staff since the last inspection and introduced assessments to check that staff understood it.
● Staff members were competency assessed and received training to handle medicines.
● Medicines including those that required extra safety security were stored securely and kept at appropriate temperatures.
● Staff recorded waste medicines on designated forms before disposing them via their waste medicine bins.
● There was adequate stock of prescribed medicines.
● Information was available in care plans to guide staff on how to manage and monitor side effects of high-risk medicines such as insulin and anticoagulants.

Staffing and recruitment
● The service had been successful in recruiting staff to the team to fill vacant positions. During the inspection we observed staff were visible and call bells were not prolonged when people requested assistance.
● Staff told us there was enough staff to support people safely commenting, "Staffing has been fine, no problem. We all pitch in where needed to make it one team."

Preventing and controlling infection
● The service was clean, tidy and free from odours. People we spoke with confirmed that the service was always clean and well maintained. One person told us "Very clean yes. Hasn't changed during lockdown. There are some very good staff working here."
● The service had a clear infection control policy, this was up to date and had been updated in response to the Coronavirus pandemic. The service had a protection and prevention plan in place to manage the risks and their response to the pandemic effectively.
● The service used personal protective equipment (PPE) appropriately. Staff had received training on how to use PPE in line with national guidance.
● There was infection control guidance for visitors to the service. Signs explained procedures that visitors should follow to reduce the risk of spreading infection. There was alcohol gel and hand washing stations

throughout the service.

● At the time of the inspection the service was completing a two week lockdown due to having two confirmed cases of Coronavirus. The two people, who were isolating, had not displayed any associated symptoms and had since tested negative but the service was continuing with these measures to reduce risk.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to 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

At the last inspection in January 2020, the provider demonstrated that improvements had been made to keeping and following appropriate records of care. However further time was needed to embed those changes in order to be meeting the requirements of the breach of HSCA RA Regulations 14 Regulation 9 breach and the Warning Notice served had not been met. At this inspection we found that whilst the provider had now taken enough action to not be in breach of Regulation 9 HSCA RA Regulations 2014 Person-centred care, there was still some outstanding actions needed. We have therefore made a recommendation for the review process of documentation.

- Care plans had been re-ordered to be clearer in the layout and finding specific information needed. An example page of 'top tips' was available to give staff guidance when completing daily notes. Care plans had information recorded but some we reviewed needed more detail to support staff and evidence people's involvement.
- Resident profiles helped aid staff to know important details about people's preferences. For example, if they preferred a male or female staff member for support and things they liked to keep close to them.
- Staff completed daily records each time they supported a person with their care needs. We saw that these were mostly improved with staff recording details about people's mood and presentation. The management team told us they were continuing to work with staff to make these more person centred.
- We saw that the terminology staff recorded was much more dignified and respectful. For example, one staff member had documented that they explained to a person how they would support them and asked how they were.
- Repositioning charts were being completed and we did not see any gaps in these. People had individual times of when they required repositioning support instead of a blanket response. The repositioning charts were not always completed within the specified timeframe, but this was around a half an hour to an hour as opposed to previous more significant delays.
- Not all recorded information was followed up consistently. For example, when one person told a staff they did not feel well, there was nothing recorded about how this person was supported. Another person had declined their breakfast and lunch on the 15 August and did not eat until 6.10pm that evening when they had some soup. There was no evidence that they had been offered alternatives or that any snacks had been brought to the person in between this time. Although the registered manager had implemented a stamp for seniors to evidence they had checked documentation it did not evidence if they had picked up on these issues and what had been done in response. This continues to need some improvements.

We recommend the provider reviews their system of monitoring recorded evidence in order to take action accordingly and drive improvement.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Information on people's communication preferred techniques and how to support them was detailed in care plans. For example, one person struggled at times with word finding so staff were encouraged to prompt, give options and allow time for the person to prepare their responses.

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
● The normal schedule for activities had been postponed due to the pandemic and restrictions in place. People had been receiving more one to one activities and staff had helped people maintain contact with their families.
● An activity photo board was displayed in the entrance. We saw people had celebrated VE day, painted rainbows and written messages for their families. Fridge magnets had been painted and were being sold and proceeds donated to Wiltshire Air Ambulance.
● One staff told us, "We have been sending things to families in the post, it's been hard for people as they haven't seen their families for five months. We have face timed them and keep in contact. Relatives we spoke with confirmed they have received contact from the home and updates about their family member. One relative commented, "They have been proactive, in terms of having letters and photos which was nice and newsletters from organisation about Coronavirus."

End of life care and support
● At the time of this inspection one person was being supported with end of life care and two people were receiving palliative care. We reviewed people's care plans for how they wanted to be cared for at this time and saw some information had been recorded. Where there were gaps however, it did not state if this information was pending or if the person had chosen not to answer. There was nothing recorded about if this would be revisited at a later date.

Improving care quality in response to complaints or concerns
● The service had not received any complaints directly since our last inspection. The registered manager told us he believed it may be because of the increased contact staff were having with families during this time.
● We saw that compliments had been received thanking the staff for their care and hard work and the measures implemented to keep people safe during the pandemic. One staff member told us, "On the whole families have been fairly understanding about the measures we have taken."
● Relatives we spoke with confirmed they had not raised any complaints and were satisfied with the service. Comments included, "Not raised any concerns about anything they have been good, [person] is eating well and is gaining weight. Carers are nice to [person] and it takes the worry off you" and "[Person] is quite capable of speaking out. They have had problems and I don't know how they are doing now but guess it's as good as can be and [person] doesn't complain."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

● During our inspection we identified a notification of alleged abuse that had not been notified to CQC. The management team told us this was an oversight on their part. Following this inspection, we received a whistle-blowing concern about a second incident of alleged abuse. The registered manager had been made aware of this but had again failed to notify CQC and ensure people were safe from the risk of harm.

The failure to notify the Care Quality Commission of incidents of alleged abuse is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, we were informed that internal action is being taken with employees to address this concern.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last comprehensive inspection in September 2019 we found that although some aspects of the service had improved, the provider had failed to ensure people received a consistently safe and good service. At this inspection we continued to see a lack of sustained improvements made in a timely manner. The service remains in breach of Regulation 17 for a third consecutive time.

● The service had continued to complete regular quality monitoring of the service. A report of improvement actions was in place and updated as the service progressed.
● The provider had carried out monthly internal medicine audits with actions derived from them. The audits had made some improvements. However, further improvements identified by the audits related to protocols for when required medicines and short-term medicines were needed.
● The service had recently had an internal inspection conducted by their quality team which found they scored 91% overall. We continued to find in some areas a lack of evidence to show issues had been identified or action taken. This was prevalent in risk assessments, raising notifications, care plans and monitoring charts. The registered manager explained that verbal actions had been taken and they were still working with staff to record actions. This continues to require improvement at this inspection.
● We saw that three infection control audits consecutively identified issues with hand hygiene for staff but the improvement was simply to talk to staff. This had not been effective as an improvement action to drive change. The registered manager told us they were ordering an ultra violet light detector to use in staff

meetings to raise awareness, however this had not been documented to evidence issues were being actioned.
● Staff meetings had continued during the pandemic lockdown. We reviewed the minutes of these and saw that conversations had taken place around the pandemic, the atmosphere in the home becoming more positive and the improvements being worked towards.

The lack of action to drive and sustain improvements is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was mixed feedback given by staff during this inspection about the culture of the home. Comments made alluded to a divided staff team that had been with the previous organisation and stayed when HC-One took over and then newer staff who had joined. One staff told us the morale was high and there was a strong sense of team. Other staff commented, "I don't want to work anywhere else, if one person gives me a smile that's made my day", "The older staff members, the BUPA crowd are clicky and the registered manager does not say anything to them. I am embarrassed to say where I work, it has a bad reputation" and "There is a culture of bullying within the home. There is also personal connections within the home due to having lots of family working with each other which creates an atmosphere of favouritism."
● Most staff told us they felt supported by the registered manager and had seen improvements, however some felt when they raised concerns these were not acted upon. Staff told us," Can go to [registered manager] no problem at all and would raise anything that was a concern and that I wasn't happy with", "They certainly improved a lot when [registered manager] took over", "Since the new manager has come, the standard has definitely gone up. Things that need seeing to are sorted, you know someone is in charge now, which is good" and "Concerns I had raised were not being taken seriously by the Home Manager."
● Relatives spoke positively about the registered manager and his approachable nature commenting, "He is very approachable, he always comes in and talks to us and say hello" and "When we went in [registered manger] was very available. Staff are always very available on the front desk."
● The atmosphere during this inspection was calmer. We observed staff were talking with people in respectful ways and offered unrushed support where needed.
● Staff were open that it had been difficult at times during the pandemic but they had continued as normal. One staff said, "As staff we have talked about it together and to each other, we don't let residents see any panic, we just want them to be happy."

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 manager was aware of their responsibilities under the duty of candour.
● People and their relatives were aware of who the registered manager was and how to contact him if needed.
● Relatives told us the registered manager was responsive when they contacted him and available when needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although the annual provider feedback survey had been postponed this year due to the pandemic, the service continued to monitor people's experience during one to one interactions. One staff told us, "Staff have done a lot about peoples wellbeing and keeping people in touch to see they are happy. This has on the whole kept people happy and in touch with the outside world. We daily monitor how people's moods are."

● We saw that photos were displayed of which nurses were on duty and a photo of the registered manager for people to be aware and know who to approach if they needed. Notices had been displayed that CQC were visiting and when so people could be kept informed.

Continuous learning and improving care

●The management team spoke about the changes they had implemented to improve the service and were continuing to work towards. The biggest change had been moving their medicines room and changing the dispensing pharmacist. The registered manager told us, "We have done really well with recruitment, got a really good positive staff team. They want to provide the best support to people."

● The management team spoke about the changes they had needed to make during the pandemic, some of which had been positive. The registered manager commented, "We have learnt new ways of getting in touch with relatives and after COVID 19 we will continue this as it's enhanced people's lives."

● Relatives had not been visiting the service since March 2020 and told us they were not aware if there had been improvements within the service. Comments included, [relative[hasn't had any complaints about things, it's not gone up or down" and "I haven't heard of any improvements as such, from [person's] perspective they have always enjoyed the food and always liked the activity staff. I can't fault that side of it. [person] is supported."

Working in partnership with others

●The management team told us they had felt supported by external professionals during this pandemic commenting, "The GP has continued to be brilliant and is visiting twice a week. We have had good links with the Speech and Language team (SALT) and Tissue viability nurses (TVN) and skyped or been on the phone if not visited. Public health England have been good with any positive cases and Wiltshire Local Authority had maintained constant contact."

● The registered manager also felt well supported within the organisation and told us, "I have had too much support, been really good, as a management team we support each other really well."

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 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the Care Quality Commission of incidents of alleged abuse. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to protect and keep people safe from abuse and improper treatment. Regulation 13 (1) (2) (3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to mitigate risk and keep people safe from potential risk of harm. There was continued improvements needed in managing medicines safely. Regulation 12 (1) (2) (b) (g)

The enforcement action we took:

A positive condition has been applied to the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of action to drive and sustain improvements in the service is a continued breach. Regulation 17 (1) (2) (a) (b) (f)

The enforcement action we took:

A positive condition has been applied to the provider's registration at this location.