Avon Care Homes Limited

The Wells Nursing Home

Inspection report

Henton
Wells
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20 November 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 20 November 2018 and was unannounced.

The Wells Nursing Home 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 home is registered to care for up to 40 people. At the time of the inspection there were up to 31 people were living at the home. Some of the people living at the home complete short stays and then return to their own home. The home specialises in caring for older people who require nursing and personal care needs. People live across two floors in the home and on the ground floor there are communal spaces including a living room and dining room.

Although there was registered manager in place to run the home they were no longer the person responsible managing the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager who was running the home.

People were not always safe living at the home even though they thought they were. Medicines were mostly managed safely and improvements had been made in the cleanliness of the home. There were systems in place to monitor health and safety and fire. However, improvements were required in relation to keeping people safe who required specialist diets, pressure care and risk assessing. Records for people were sometimes inconsistent or lacked guidance for staff.

People were protected from potential abuse because staff understood how to recognise signs of abuse and knew who to report it to. There were recruitment procedures in place. However, these had not always been followed when staff were recruited. Staff had not always received supervision and training to be able to meet people's needs and wishes.

The management were striving to make improvements when shortfalls were found in their auditing systems. There was external scrutiny provided by the provider and when additional bodies found concerns this had led to improvements. However, statutory notifications were not completed in line with legislation to inform external agencies of significant events.

People and relatives continued to tell us they liked living at the home. People were being encouraged to provide feedback on the home and make suggestions to improve the service they received. Their complaints were listened to and action taken when it was required.

People were supported to have choice and control over their lives and staff supported them in the least

restrictive way possible. However, records did not reflect the processes which had been followed to ensure it was in line with current statutory guidance.

Most people enjoyed the food they were served at the home. People told us their healthcare needs were met and staff supported them to see other health professionals. However, there were occasions other health professionals had not been contacted in a timely manner.

Improvements could be made because care plans did not always reflect people's current needs and wishes. The service needed to ensure all parts of care plans were updated when there was a change in a person's needs. Although some people had their end of life needs and wishes considered, this was not consistent.

People and their relatives told us, and we observed, that staff were kind and patient. People's privacy and dignity was respected by staff. People, or their representatives, were involved in decisions about the care and support they received. The staff tried to ensure care and support was personalised to each person which ensured they could make choices about their day to day lives. People were consulted about the activities they would like to participate in. There were opportunities for cultural and religious needs to be reflected in the choices.

We have made a recommendation about the provider seeking guidance around capacity and consent.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One breach of the Care Quality Commission (Registration) Regulations 2009 was also identified.

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.

People were put at risk because their current care plans lacked guidance for staff and risk assessments had not always identified actions to mitigate known risks.

People were not always protected from the risks associated with poor staff recruitment because the procedure was not always followed for new staff.

People's medicine was managed safely.

People had risks of abuse or harm minimised because staff understood the correct processes to be followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the skills and knowledge to meet their needs.

People who lacked mental capacity did not always have decisions recorded in line with current legislation.

Most people had been assessed prior to moving into the home.

People had access to medical and community healthcare support.

Is the service caring?

Good

The service was caring.

People were offered choice and their decisions respected.

People's privacy and dignity was respected by staff.

People's needs were met by staff who were kind and caring.

People's cultural and religious needs were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs and wishes regarding their care was not always understood and care plans lacked important information to provide guidance for staff.

People did not always have a dignified death planned with them.

People benefitted because staff made efforts to engage with people throughout the day.

People knew how to raise concerns. Systems were in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider was not fulfilling their legal responsibilities because notifications were not being sent to the commission.

People were using a service which had external scrutiny and the management were striving to make improvements in line with this.

People were supported by management who made changes to systems when it was identified things could be improved.

People benefitted from using a service which had staff who felt supported and listened to.

The Wells Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 20 November 2018 and was unannounced.

This inspection was carried out by one adult social care inspector, a nurse specialist adviser and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information that we held about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us. We also spoke with the local authority on the telephone who shared information.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 people who used the service and eight visitors including relatives and health and social care professionals. We also spoke with 13 members of staff. This included the provider's consultant nurse, the registered manager from another home, the home's new manager, the previous registered manager, nursing staff, care staff and ancillary staff.

During the inspection, we looked at 10 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records. We reviewed

records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

We asked for responses within a short time frame and information following the inspection. All of this was provided within the time frames given.

Requires Improvement

Is the service safe?

Our findings

People were not always being kept safe at the home. Some people requiring specialist diets and thickened drinks to prevent aspiration and choking were placed at risk. All people requiring specialist diets were given the same softened food. One person had been given this food at lunch time. No staff knew or understood what type of softened diet they should be eating. Their care plan gave guidance which was different to the last speech and language therapist assessment from October 2012. The manager and the provider's nurse consultant were unable to confirm there had been a more recent review. Although no harm had occurred to the person they were being placed at potential risk of aspiration or choking. Another person requiring a specialist diet had no record of being seen by a speech and language therapist to make sure their food was being safely prepared.

One person was seen being assisted to drink by a staff member. There was confusion about what thickness this drink should have been and the person's care plan lacked guidance. Some people had pictorial guides which did not clearly state exactly how to prepare their thickened drinks. Nor was the special thickener stored securely in two people's bedrooms. This meant there was a risk of unauthorised people consuming it. No staff had received appropriate training to understand how to safely support people requiring specialist diets. Following the inspection, the provider updated us with action taken to reduce the risks to people around eating and drinking.

People were not always protected from potential risk around pressure ulcers. Those identified at risk had specialist air mattresses on their beds. The settings of most of these were routinely checked and were correct during the inspection. However, one person had recently started a short stay at the home with a significant pressure ulcer. There was no wound care plan to identify what treatment the nurses should be completing. No photographs had been taken to record the management of the ulcer so it could be monitored. There was no information about what their air mattress should be correctly set at or checks. By not having these records and checks in place there could be inconsistencies in their treatment and no way to determine if they were responding to treatment. During the inspection the person's wound was checked and it was improving.

Records were not always being completed or kept up to date to keep people safe and meet their needs. Daily logs were being kept in bedrooms to monitor people's fluid intake and repositioning. There was no target to ensure the person was receiving enough fluid. Nor were there details how frequently a person needed to be repositioned to prevent pressure ulcers even if within a person's care plan there were details. There were occasions these records had not been updated since the early morning. One person, who was frail, was found with a very dry mouth and low fluid intake recorded. No mouth care kit had been considered if the person was unable to sip fluids. The nurses made sure this was put in place. Following the inspection, the provider informed us they had updated processes to ensure fluid and repositioning records were being completed.

People were placed at risk of harm because other agencies had not always been contacted in a timely manner. One person with limited mobility was found in pain by a member of the inspection team. Staff had

completed pain monitoring records and on three recent dates these demonstrated high levels of pain. No additional pain medicine had been offered on these dates even though it could have been. There were five other dates when the charts indicated additional pain medicine should have been offered. No reassessment by the person's GP had been requested. This meant the staff were not responding to the person's current needs. During the inspection the manager arranged for the GP to reassess the person's pain management.

Most risks had been assessed and ways to mitigate them found. People's care plans had their nutrition, pressure care needs and mobility recorded. However, there were occasions these were not being regularly reviewed to ensure they were still applicable and in line with people's changing needs. One risk relating to members of staff living in the home had not fully been considered. Although the management provided a short policy about rules in place for these staff and prohibited items. It had not demonstrated all the risks to people had been identified and mitigated.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment was not being completed in line with current legislation to keep vulnerable people safe. The provider had systems in place for recruitment including checks from previous employers and criminal checks. However, two staff had not got full employment histories and one staff had a gap in employment which had not been checked. One staff member had a reference which did not match their employment history. Another staff member had references which did not demonstrate they were from a previous employer. This meant they had not completed pre-employment checks in line with their own policies and current legislation. Following the inspection, the provider updated us with further information and actions they had taken to rectify the employment checks.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A majority of people and relatives thought there were enough staff to meet their needs and keep them safe. One person said, "Yes, enough carers. There is enough staff to give me the help I need. I see the same staff. I have a call bell. They come right away". Whilst other people told us, "There seems to be enough staff" and, "Enough staff? Oh yes. They are pretty brilliant for answering the bell". One relative did say, "They could do with more staff. There could be more at meal times".

However, staff were less positive about whether there were enough staff. Two members of staff told us they were always very busy. This was because so many people needed two members of staff supporting them for certain tasks such as intimate care. Another member of staff told us they saw the care staff always busy and did not think there were enough staff. The provider and manager were actively finding solutions to increase the numbers of staff. They used regular agency staff and nurses from the provider's other homes completing shifts. We saw information about staff who had recently been through the recruitment process to try and improve the situation. The manager shared at the staff meeting further ways they were going to increase staff levels at key times of day.

Medicine was mainly managed safely. People had their medicines administered following their preferences and on time. When people had 'as required' medicine there was guidance in place to ensure consistency. Storage of medicines requiring a fridge was safe and there were regular temperature checks. Medicine trolleys were secured to walls and locked when not in use to prevent unauthorised people accessing them. Medicines requiring additional security were checked weekly to ensure the stock was correct. However, they had not always been correctly recorded when transferred between records. This meant medicines in stock

could have gone missing without staff realising.

People and relatives thought the home was safe. One person said, "Yes, I feel safe because I have a nice room and have no complaints". Other people told us, "I feel secure here" and, "Oh yes. I'm nice and safe. Everything here makes me safe". One relative told us, "The staff give me piece of mind. They are like extended family".

Staff knew how to keep people safe from potential abuse. They could describe how they recognised signs of abuse. All staff knew who they should report the abuse to and they all felt something would be done. If they were still concerned they knew external bodies they could raise their concerns with to keep people safe.

There was a system in place to monitor accidents and incidents. When any happened, the management investigated them. Ways to reduce the likelihood of reoccurrence were explored. For example, one person nearly slid out a sling whilst being hoisted. Staff had prevented the person falling. Following the incident there was retraining for all care staff around using the hoist. However, there were occasions the management forgot to document the outcome of the accident or incident. The manager told us they would make sure this did not happen in future.

People were kept safe because most health and safety around the home had been considered. Specialist tests had been completed on the quality of the water. Lifts and lifting equipment had been routinely tested to ensure they were safe. There were regular checks to ensure people were being kept safe in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

People were not always receiving effective care. Staff had received some training to meet the needs of the people they supported. Two members of staff said they had completed training classed as mandatory by the provider. However, they both felt they had not received enough training to meet people's specific care needs. One member of staff told us they were completing tasks delegated by nurses to them. They had not received recent training to complete these procedures safely. The manager and provider's nurse consultant were unaware of this practice and said it would stop immediately.

Concerns found during this inspection highlighted staff appeared to lack knowledge and understanding on certain topics. For example, no staff had received training around specialist diets. Some ancillary staff were helping at mealtimes and had not received training in how to do this safely. The activity coordinator had not received specific training around running activities. They did not have any qualifications in relation to their current role. They told us they would really like to learn more about their role. The provider's training records demonstrated these shortfalls in staff training. The manager and nurse consultant informed us they would be addressing some of these concerns immediately to ensure people were receiving appropriate care and support. Following the inspection, information about what actions had been completed and an action plan to address other areas was sent to us.

There was a mixed opinion about how well staff felt supported and whether they had supervisions. Supervisions were an opportunity to celebrate what was going well and any concerns. They were a place to discuss training opportunities. One member of staff told us they had supervisions and led them with other staff. However, one member of staff felt they were not receiving regular supervisions. This meant they did not have the opportunity to discuss any concerns they had. They were hopeful the new manager would be changing this situation. No staff told us they had observations to ensure people's care was being delivered in line with best practice.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction which included shadow shifts and support from senior staff. If they were new to working in care they worked through the Care Certificate. The Care Certificate is a nationally recognised standard to make sure all staff working in care have basic skills to look after people.

People who could consent were asked by staff before being supported. One person said, "Oh yes. They ask permission". Some people in the home lacked capacity to make specific decisions for themselves. 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 Act 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff understood how to apply this to the daily support people received. They knew to ensure decisions were made with the person in mind. They knew to ask family members or other professionals if it was a bigger decision. One relative said, "They talk things through and ask [before delivering care]. I am involved in best interest decisions. Daughter's rights. They communicate with me". However, records did not reflect staff knowledge about decision making for people who lacked capacity. Decisions made in a person's best interest had not always been reviewed regularly.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made applications for some people to be deprived of their liberty to keep them safe. However, one person's care plan stated they had capacity yet a DoLS had been applied for. The manager told us the person's capacity had changed which was why the application had been made. There was nothing to demonstrate the statutory guidance had been followed in line with this observation.

We recommend that the service seek advice and guidance from a reputable source in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

People had a positive experience during meal times and had most of their dietary requirements and preferences met. One person said, "The food is good, and the service is good". Whilst others told us, "I like the food" and, "The food is very nice". There were some people who felt more options at meal times could be given especially for dessert. Meal times were a social occasion for those eating in the dining room. There was conversation amongst people during their meal. However, staff were incredibly busy and were predominantly undertaking task based discussions rather than joining the conversation.

People requiring assistance were transferred to the dining room and enabled to eat at the table in a safe, caring manner at a pace led by the person. Whilst some people chose to stay in their bedrooms. Two people said, "Yes, I do have choice. I choose to go to the dining room for lunch" and, "They respect my personal choice to eat in my room". Staff would support them when it was required and take time to help them eat. The menus were varied and prior to meal times people were offered a choice of food. There was no visual support or menu available to remind people who had memory difficulties what the options were in the dining room. All meals were brought to people covered so they did not get cold.

When people felt unwell they could see a health professional. One person said, "If I'm not feeling well the staff would pick up on it quickly. Oh yes. No time waiting to see a doctor". Another person told us, "Oh yes. I could see the doctor quickly if I needed to". Most relatives agreed with this. One relative said, "If they [meaning the staff] are not happy they call the doctor. I have no worries. They call me if there's a problem". However, examples were found during this inspection where health professionals had not always been contacted in a timely manner. If people had specific health conditions they were supported to see specialists in relation to this.

Assessments were carried out for most people who moved into the home. A member of the management met with the person and their family. They also obtained any records if the person was moving in from another care service. One person had recently moved in. The management had gone to the other care home to complete an assessment. The manager had also obtained a copy of the person's care plan from the other home. This was used to help write the new care plan. However, there were occasions when people and relatives were unsure whether an assessment had occurred.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. One person told us, "The care is brilliant. I couldn't wish for better". Whilst others said, "The staff are friendly. I'm very happy with the care" and, "I'm very happy here. Yes, they are caring". People unable to communicate verbally nodded and smiled when asked if they were comfortable living at the home. One relative told us, "My [name of person] has been happy here. The staff are like extended family. No issues with the staff". Another relative said, "Yes, they are very kind and caring. [Name of person] gets on well with them. They are brilliant with [name of person]".

People appeared comfortable around staff. They were smiling and enjoying interacting with the staff. When people became upset staff tried to comfort them. One member of staff said, "We work hard and enjoy it because of the residents. We love the residents". Many kind, caring interactions between staff and people were witnessed by the inspection team. Staff demonstrated knowledge of individual needs and were respectful and patient.

People could make choices and these were respected by staff. One person said, "Yes, I have choice, getting up and going to bed. Otherwise I look after myself". Whilst others gave examples of when they had been offered choice. Such as when they had their bath and where they ate. Some people felt there were specific times they would like more choice such as meal times. There were occasions when the choices offered by staff could have been more appropriately said. For example, at meal times instead of being offered the flavour of squash to drink they were asked if they wanted "Red or yellow".

People's privacy and dignity was respected. One person said, "Oh yes, they respect your privacy and dignity when providing personal care. They are very nice and caring when they come to wash you, whether it's a woman or a man". Another person described some intimate care the staff supported them with. They told us, "They keep my dignity when they do that [meaning the intimate care]. They speak to me nicely". All staff knocked on people's doors before entering their bedrooms. One person told us, "They speak nicely to me and knock or call before entering my bedroom".

Visitors were welcomed to the home and people were supported to see them in private or a communal space of their choice. One person said, "Visitors are not restricted at all. My family are made welcome. They just come and go as they wish". Other people told us about all their family members who visited them. Relatives were very positive about the welcome they received at the home. One relative said, "When I visit, they give me a cup of tea and the staff have a chat".

People were supported by staff who respected their cultural and religious differences. One person clearly found religion very important to them. Their care plan reflected this and their bedroom reflected their beliefs. One member of staff explained there was a multi-cultural staff team as well. They told us at the home they, "Celebrate diversity".

Requires Improvement

Is the service responsive?

Our findings

People did not always have their end of life needs considered or personalised to meet their wishes. One person had it clearly documented that it was their choice not to discuss this topic and staff had respected their wishes. Another person's care plan gave guidance to staff to contact the person's family and stated what their last wishes were.

Some care plans contained generic statements created by an electronic care plan system. This meant there were some guidance for staff to follow. However, the information had not always been updated regularly to ensure it was in line with their current needs and wishes. Two care plans looked at had nothing about what their end of life wishes were and to ensure they were followed by staff. The provider and manager had already identified this as an area they would like to improve. They explained they were prioritising areas like recruitment of nurses, who updated care plans, so this could be rectified.

Care plans were in place for people. At times these reflected people in a way that respected them as individuals and took account of their likes and dislikes. Some clear information was provided to staff about people's needs and preferred routines. One person's care plan had guidance about their communication and family history. Other people had guidance if they had specific care needs which needed meeting.

However, there were many occasions when care plans had not been updated or reviewed to ensure the care reflected the person's current needs and wishes. There were times when care plans lacked details and guidance in areas to inform staff how to support people. These have been reflected in other areas of the report. The home regularly accepted people for short stay placements. Sometimes the care plans had not been completed with important information in a timely manner. For example, one person who had recently began a placement did not have guidance about specific needs to prevent harm.

The provider and manager had already identified some of the shortfalls in the care plans. They were putting additional training in place for staff to use the electronic care plans. Additionally, at the staff meeting during the inspection staff were being encouraged to share all their knowledge of people's most current needs and wishes so care plans could reflect this.

Activities were available for people to attend in the main living spaces of the home. One person said, "Activities? They take you on outings. We've been to the water places; not that often. You don't have to pay for it. There is a hairdresser that comes and does our hair". Another person told us, "Activities. No, I don't go. Not that fussed". There was an activity coordinator who arranged these sessions. On the first day of inspection six people and three relatives attended a pottery session in the dining room. The session appeared to be engaging and enjoyed. People were proud of what they made and showed the inspection team past work which was of high quality.

The activity coordinator arranged for a range of activities and tried to involve people's hobbies and interests where they could. They tried to visit people in their bedrooms if they were unable to attend the activities so they could have time with them. However, there was limited time the activity coordinator was working in the

home. This meant at other times people were left to entertain themselves. Also, recently the tables had been changed in the communal spaces. By not having individual tables it made it more difficult for some people to participate in activities.

We discussed with the manager and other members of management how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand. The manager told us this was an area they would be developing in line with work they were doing since joining the home. They were not fully aware of the standard so would familiarise themselves with it and make sure different methods of communication were explored to meet people's needs.

The provider had policies and procedures in place to manage complaints. These were given to people when they moved into the home. Most people and relatives had nothing to complain about. People said, "I have no complaints", "I'm very happy here", "I have no complaints" and, "If you've got any complaints, they will see you". The manager talked us through how they handled complaints which came to them. They took them all seriously. However, the complaints policy did not contain information about who to complain to if people were not happy with the initial response from the provider.

Requires Improvement

Is the service well-led?

Our findings

Some notifications were being sent in line with legislation to allow us to monitor the care and safety of people. However, there were occasions notifications had not been sent in line with statutory requirements. One person had started a short term stay at the location with a pressure ulcer. No notification had been sent. Two other people had significant pressure ulcers. Due to the circumstances around them the local authority safeguarding team had been informed in both cases. Notifications had not been sent in line with legislation for either person.

This is a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Since the last inspection there had been a change in management of the home. Although the registered manager was still present they had changed their working patterns so were now one of the nurses. The new manager was just starting the process of registering. People and their relatives were positive about the new manager. However, this change in the management had caused some confusion. Some people were confused who was the current manager of the home. There were occasions when staff told us they would go to the previous registered manager rather than the new one.

People and relatives liked the new manager and spoke positively about them. One person said, "The manager is approachable". Relatives told us, "The new manager is approachable. There is a good atmosphere. It is lovely here". Staff were positive about the new manager as well. They thought they were approachable and could speak with them about anything.

The new manager and provider recognised there needed to be improvements made at the home. One of the initiatives was to have all the people requiring nursing on the top floor. This would mean those more mobile were near the communal areas and be able to independently move around. Whilst those requiring more in-depth support could be near nursing support. Other areas of improvement which had been identified included the electronic care plans, staff levels and protected meal times.

When concerns were found at provider level additional support was being put in. Registered managers from the providers other homes were coming to mentor and support the new manager. Additionally, specialists such as registered nurses who were part of the quality team were helping to drive up standards. If there were staff issues then the human resources department offered support.

The management were responsive to concerns raised by external bodies. After the local authority had completed a joint visit with a member of the provider's team a new head housekeeper was employed. This was because it had been identified that improvements were required to reduce the risk of the spread of infection. At the time of the inspection no concerns were found. New systems and auditing had been put in place which were completed regularly. Following the inspection, a range of actions were sent to us which had already been taken by the provider and new manager to improve the quality and safety of care people were receiving. This included additional specialist training for staff and sourcing input from other healthcare specialists.

The provider tried to involve people and staff in driving changes. One relative said, "Yes, they would listen and make changes" when questionnaires have been sent out. There were resident meetings held and people told us changes happened in relation to them. Records showed actions were identified from this and then responded to. During the inspection there was a staff meeting to discuss changes which were being introduced by the management. The manager provided opportunities for staff to contribute and make suggestions. They also fed back actions that had been taken in response to previous suggestions. For example, additional time was given to auxiliary staff to complete their tasks in response to them supporting more at key times of the day such as meal times.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed in their legal obligation to notify CQC of significant events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to undertake robust and safe recruitment of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. The provider had failed to ensure staff received appropriate support, training and supervision.