

Shaw Healthcare Limited

New Elmcroft

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

New Elmcroft is one of a group of homes owned by a national provider, Shaw Healthcare Limited. It is a residential 'care home' which can accommodate up to 60 people in one adapted building. The care home provides accommodation and nursing care for people living with a range of healthcare needs and disabilities associated with older age and frailty, including people living with dementia. There were 46 people living at the home at the time of our inspection.

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

People did not always receive care in line with their assessed needs and plans of care. People did not consistently receive safe wound care as guidance from health professionals was not always followed to ensure risks to people's health and safety were mitigated. People were not always monitored for changes to their health following a fall as staff had not always followed the provider's processes to keep people safe. Staff did not always have all the risk information required to ensure potential risks associated with people's health conditions were managed effectively.

Systems to monitor the quality and safety of the service were not robust enough to identify shortfalls in people's care, communication or records relied upon to demonstrate the care people had received. The service had a new manager who had begun to implement changes to improve the standard of care and overall governance of the home. However, these changes were not yet embedded or sustained and required more time to embed them in everyday practice and monitor their overall effectiveness to improve people's care.

People's and most relative's experience of using the service was positive. People told us they felt safe and were cared for by staff who knew them well and understood their needs. Staff understood their safeguarding responsibilities and knew how to escalate concerns. There were enough staff to meet people's needs and changes made to the skill mix and deployment of staff, meant nurses had more time to provide care for people.

People and their relatives thought the home was clean and hygienic and people were protected from the risk of infection. Comments included, "The home seems clean and [person's] room is well maintained", and, "The home was clean when I visited before and staff were all wearing PPE, as did we as visitors."

People received care that was responsive to their needs. People were offered choice and their preferences respected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's communication needs were assessed, and people had access to information in the way they preferred when needed. People were offered a range of activities which would promote their emotional

wellbeing and reduce the risk of isolation. People were supported to maintain contact with their loved ones and this continued if the home was closed due to COVID-19. One person's relative told us, "The home arranged video calls at times when we couldn't visit."

People received care and support at the end of their lives which was in line with their wishes and preferences. The managers acted on feedback and had taken action to enhance the quality of care people received at the end of their lives.

The managers of the service promoted a positive and person-centred culture which aimed to achieve good outcomes for people. Most feedback received was complimentary about the way the home was managed and the care people received. One person told us, "I enjoy it here, it is different from anywhere else and you know you'll have a good time. The staff are very good really, I have no problems at all."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 23 August 2018).

Why we inspected

We received concerns in relation to wound care, end of life care and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this full report.

During and after the inspection, the provider took appropriate action to ensure any potential risks to people's health and safety were mitigated. The manager provided assurance that concerns identified during the inspection, and others identified through their own quality assurance processes, would be addressed and actions taken to make the required improvements.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well led.

Details are in our well led findings below.

Requires Improvement ●

New Elmcroft

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.

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

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

Service and service type

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

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The service had a new manager who had recently started working at the home having moved from another of the providers services. They had started the process to become the registered manager at New Elmcroft.

Notice of inspection

This inspection took place over two days. The first day was unannounced and the second day was announced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection and information we had about the concerns. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 11 people who used the service and one relative about their experience of the care provided. The Expert by Experience contacted eight relatives remotely by phone. We spoke with 16 members of staff including the manager, assistant manager, operations manager, quality improvement manager, registered nurses, team leaders, activity staff, care workers and the chef.

We reviewed a range of records. This included 10 people's care records, multiple medication records and records relating to the management of the service. We looked at training information, quality assurance and audit documents and the providers policies and procedures. We looked at three staff files in relation to recruitment and staff supervision.

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 requires improvement. At this inspection this key question has remained the same. 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

- Most people had risk assessments and management plans which identified risks to their health and safety and provided guidance for staff on how to manage them. However, not all people consistently received care and support in line with these plans. Prior to this inspection concerns had been raised about wound care management. At this inspection we found people living with wounds had not always received care in accordance to their assessed needs. Although advice from external health professionals had been sought and implemented, and people had care plans which guided staff on how to provide safe care, staff had not always adhered to this guidance. One person's wound was not adequately monitored for 10 days, another person for six days. Therefore, any signs of decline in the person's health would not be identified in a timely way so appropriate action could be taken. Records in relation to wound care did not clearly demonstrate what care people had received. Staff had recorded wound care in two different locations and told us they were not certain what system was in use and did not know where to find the most recent care plans. This increased the potential risk of further decline in people's health.
- People who experienced a fall were not always monitored for signs of deterioration to their health. For example, one person had fallen and sustained a bump to their head. Although medical advice was sought after the injury was identified, the person was not subject to increased monitoring in line with the providers falls policy. This increased the risk that any changes in the person's clinical presentation may not be identified and acted upon in a timely way.
- People living with long term health conditions such as diabetes did not always have care plans with enough risk information to enable staff to identify changes in people's health that might indicate their health was deteriorating. For example, one person's care plan lacked guidance for staff on what signs and symptoms to look out for and action to take should they become unwell. This meant staff did not have all the information they might need to provide safe care should the person's clinical condition change.

This was raised with the provider during the inspection. The managers were responsive to our feedback and told us what actions they had taken to mitigate the risks identified. This included further training for staff on how to use the electronic record system, an update on clinical procedures for managing falls, revised processes for more effective communication and updated care plans for diabetes management.

- At the last inspection people were not always safeguarded from harm as external healthcare professional's advice had not always been followed by staff. People assessed as at risk of choking and required their drinks to be thickened had not received their drinks in accordance to health professionals' recommendations. At this inspection improvements had been made. Staff had undertaken training in dysphagia awareness and the International Dysphagia Diet Standardisation Initiative (IDDSI). People with

dysphagia have difficulties swallowing and may require a modified diet to reduce the risk of choking. Staff used the IDDSI framework to ensure people received fluids and correctly modified textured foods. A robust system for ensuring people received the correctly modified foods had been implemented and all staff were aware of the processes to keep people safe. Our observations confirmed this.

- At the last inspection concerns were raised about the security of the home. Locks and keypads had been installed to ensure people's safety, yet a door to a potentially unsafe area had been left open. During this inspection we found the home was secure. When asked about access to restricted areas one staff member explained, "The storeroom is locked and kept locked all the time. Doors are closed and staff need a fob to get in there."
- The service was working within the principles of the MCA and legal guidance. Deprivation of Liberty Safeguards (DoLS) had been applied for as required and authorisations sought from the local authority. Where decisions were taken in people's best interests, these were documented and appropriate. Staff had completed training on mental capacity and obtained people's consent before providing care.

Using medicines safely

- Most aspects of managing medicines were safe. When a concern was identified, action was taken to quickly resolve. For example, people prescribed topical medicines to maintain their skin integrity had Medicine Administration Records (MAR's) which did not have clear guidance for staff as to where topical medicines should be applied. Records were completed across two different systems and showed inconsistencies in recording. This did not provide assurance that topical medicines had always been administered as directed by the GP. When this was raised with the manager, they told us they had liaised with the GP to review topical medicines and ensure they were prescribed as required and in line with people's individualised needs. On day two of the inspection we observed improvements had been made; records indicated people had been administered topical medicines as prescribed to maintain their skin integrity.
- People prescribed 'as required' (PRN) medicines had care plans to guide staff when, how and what dose of medicine was required and for what symptoms. Guidance included alternative interventions to try before the medicine was given. For example, one person was prescribed medicine to help reduce symptoms of agitation during personal care. The care plan guided staff to promote the person's independence when supporting with personal care and only administer the medicine after a specified period of time if alternative strategies were not effective.
- People were administered medicines by registered nurses or staff who had completed medicines training and were assessed as competent in the task. The manager had appointed a medicines lead to improve the oversight and management of medicines. Medicines were regularly reviewed and discussed with people or their relatives as required. One relative told us, "They [staff] discussed the medication with me. The medicines seem well-monitored and regular." Another said, "My [person] has medication for [specific health condition]. These meds have been reviewed with the nurse the end of last year."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People and most relatives told us they felt safe and knew who to speak to if they had any concerns. One relative told us, "It's safe care. [Person] has seizures and their room has alarmed mats if they fall."
- There were systems and processes to safeguard people from the risk of abuse. Staff had undertaken safeguarding training, knew how to recognise potential signs of abuse and understood their responsibilities. Staff were confident managers would report any concerns. One staff member told us, "I would watch for the way people act, see if behaviour changes. I would speak to the team leader if I was worried, document and take to [manager or deputy manager]."
- Safeguarding investigations had been carried out when required. For example, one person sustained an injury during a fall. Lessons learnt from the investigation resulted in a review of the provider's processes to

ensure risk factors associated with falls were always considered and concerns escalated so action to reduce the risk of further falls could be taken.

- Safeguarding incidents were analysed, and actions identified to reduce the risk of reoccurrence. Lessons learned from events were discussed with staff. When training or learning needs were identified, these were addressed through individual supervision, reflective practice and team meetings.
- The manager adhered to the provider's safeguarding policy and carried out their duty to report concerns to the local authority and CQC.

Staffing and recruitment

- The manager used a dependency tool to assess people's needs and make decisions about staff deployment. The manager had adapted the dependency tool to ensure this reflected the differing and complex needs of people living at the home. People's individual needs were reviewed regularly, and staff deployed accordingly.
- People and their relatives gave mixed feedback about whether there were enough staff to meet their needs. Comments included, "Staffing can vary. Sometimes the home seems to be short-staffed," and, "They are short staffed and have a lot of agency staff currently." Another person said, "I've never noticed any short-staffed times there." Our observations during the inspection and records confirmed there were enough staff to support people and meet their needs.
- The service had vacancies, however there was an ongoing recruitment programme to ensure the vacancies were filled. The manager told us they had recruited nine new staff members including a nurse, carers and housekeeping staff. The manager confirmed that currently agency staff were used to cover the vacancies and was working to ensure regular agency staff were employed from the same agencies to provide consistency and continuity of care for people. One staff member told us, "We have quite a lot of agency, but they are the same staff returning wanting to work here, it's like working with normal staff."
- Staff received a comprehensive induction and training that enabled them to competently perform in their role. Staff were recruited safely, and recruitment processes were robust to assure the manager that staff employed were of suitable character and had the right skills, experience and attitude to work with people.

Preventing and controlling infection

- We were assured that the provider was using PPE effectively and safely. Prior to this inspection concerns were raised about staff use of PPE. During this inspection we observed staff using and disposing of PPE safely. Staff had undertaken training in PPE. One staff member commented, "We wear masks, aprons, gloves, we have sanitiser. We even have the overalls if we have an outbreak." People and their relatives confirmed staff wore and were competent in the use of PPE. A relative told us, "Both we, as visitors, and the staff wear full PPE. Every measure to keep the resident's safe has been taken there during COVID."
- We were assured that the provider was preventing visitors from catching and spreading infections. There were processes in place to ensure visits were safe and facilitated in a way which reduced the potential risk of infection transmission.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service. Although the home was not open to admissions at the time of our inspection, people returning from hospital were isolated in accordance with current government guidance.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. People and their relatives thought the home was clean. A relative said, "The home is clean and hygienic. The cleaners go around regularly." The service operated a robust cleaning schedule which was regularly monitored and included the cleaning of high touch areas.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.

- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives gave mixed feedback about the times they were able to visit. One relative told us they had been unable to visit at times which suited them. Another told us they had visited regularly. They said, "Visiting has been encouraged when possible. I have a regular slot at present and I go once a week for an hour."

The provider's visitor's framework stated that relatives could contact the service to arrange a date and time that suited them. Records showed this had been raised to the previous manager who said if relatives were unable to visit in the week, then visits at weekends would try to be accommodated. The provider ensured that policies and visiting procedures had been updated to reflect current government guidance.

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 Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

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

- People received personalised care that was responsive to their needs. People had a range of assessments and care plans which contained personal information about them, their likes and dislikes, preferences and personal histories. When people were unable to give information themselves, relatives had been consulted. One relative told us, "We were involved in their care plan. We were asked about their life story, preferences and likes and dislikes. The staff seem to know about their likes and dislikes and use this information on a day-to-day basis."
- People were supported to make choices about day to day decisions such as where they wanted to be, activities they wanted to do or clothes they wanted to wear. People could state their preference of who they wanted to support them. Staff gained people's consent before providing care. A relative told us, "Staff explain and ask for [person's] permission before they deliver care." Our observations confirmed this.
- People had "Remember I'm Me" charts in their bedrooms which provided staff with a visual prompt to information about the person. Charts were personalised and guided staff as how the person preferred to be supported. For example, how they preferred their drinks, whether they preferred a shower or bath, their oral care and what they programme's they liked to watch. One person told us how they had been involved in completing their chart. They said, "I told them [staff] what to put on there."

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.

- People's communication needs had been assessed and there were care plans to guide staff on the way people preferred to communicate and have information communicated to them. Information could be adapted in a way to meet people's needs, for example, in accessible formats to help them understand the care and support available, this included people living at the service, visitors and staff. For example, the weekly activity planner was printed with large font and was available in pictorial format for people who might benefit from easy read materials. Written information was adapted for staff who may be living with dyslexia to make it easier to read. The provider had purchased a large electronic tablet device for people to play interactive games or have video calls with their loved ones. There were white boards and picture cards available to people to communicate basic information like yes, no and if they were feeling unwell.
- People had access to technology to summon assistance from staff. Call bells and sensor mats alerted staff if people needed them or required assistance. One relative told us, "[Person] has a buzzer in their room and I

know it works because I pressed it accidentally one day and the staff came within seconds."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to develop and maintain relationships and were supported to take part in activities relevant to them. The home employed two activities co-ordinators who were responsible for planning and provision of activities within the service. We observed people enjoying activities such as painting and making Easter decorations to decorate the home. People that were cared for in bed or who preferred a different activity could have one-to-one time with staff. We observed people chatting with staff in their rooms about topics of interest, or engaged in other activities such as a hand massage or having their nails painted.
- Staff knew people well and thought of creative and person-centred ways to engage them in activities that were meaningful. One person enjoyed helping with small jobs and repairs around the home, staff had purchased them a workman's overall to wear and told us, "[Person] is really happy if they're given things to do." Another person enjoyed travel and visiting new places, their relative told us, [Staff name] has been good and for our visits has suggested online tours in different cities. That would be such a nice thing to do during our visits and it would be as if we were all going on tour together." They added, "The home has helped to support links with family and friends, and we have spoken with or visited them each week. I think the staff are lovely, they are kind and warm. It is a cheerful environment and they treat my [person] with dignity. It is a home from home."
- People were supported to have contact with their loved ones throughout the COVID-19 pandemic and during the current outbreak. One relative said, "The home was closed during COVID but we were kept updated with emails and we could have video calls and phone calls throughout. The home was very good at this."

Improving care quality in response to complaints or concerns

- Complaints were appropriately investigated in accordance with the provider's policy. Managers were open and transparent when dealing with concerns that had been raised. Complaints were used to make improvements when needed. For example, in response to a complaint about a person's care, staff were supported to update their clinical practice and systems were reviewed to promote more effective communication about people's needs and changes to their care.
- People and their relatives told us they knew how to make a complaint if they needed to and complaints, although not always resolved, had been investigated. One person told us, "The staff are very good really, I have no problems at all. If I needed to complain I would do it straight away, I'm not afraid to speak up, I like things dealt with immediately." A relative confirmed, "I would always speak with the manager if I needed to complain."

End of life care and support

- Prior to this inspection we received a concern about the care people received at the end of their lives. During this inspection we did not find any evidence to support these concerns and people who had passed away received appropriate care. In response to the concern raised with the provider, additional training for staff and the managers had been arranged to enhance their knowledge and skills, and ensure staff were able to provide all aspects of care for people at the end of their lives.
- People were supported to plan their care and consideration was given to people's wishes and preferences. People had care plans which guided staff as to how they wanted to be supported when the time arose. This included detail such as who they would like to see, where they would prefer to pass away and the music and décor in their room.
- People were treated with compassion at the end of their lives, one staff member told us how they cared

for people, "It's about keeping people comfortable and free of pain. Being with them and giving regular mouthcare. I don't like people to be on their own, we reassure the person and their families."

- Staff had accessed support from the community healthcare teams and GP to ensure the appropriate medicines were prescribed to maintain people's comfort when required.

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 Good. At this inspection this key question has now deteriorated 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

- Quality assurance and monitoring processes were not robust enough to provide effective oversight of all risks to people's health and ensure people were consistently receiving care in accordance to their needs. For example, processes to ensure people received appropriate wound care had not identified care received did not always align with people's care plans, and communication about people's care had not always been consistent to ensure people's care needs were met. These concerns about staff not always following guidance set out in people's care plans were also identified at the last inspection. Although some improvements to monitoring processes had been made, improvements were still required to ensure people consistently received safe care.
- Systems had not always identified inconsistencies in records which could indicate shortfalls in people's care. Care plan monitoring processes had not always identified some people lacked up to date or accurate risk information for staff to provide safe care. Processes did not provide managers with enough oversight to ensure people had always received care in line with their assessed needs and that potential risks in these areas would be identified. This was an area of practice which needed to improve.

When this was fed back to the managers, they acted immediately to make the required improvements. It was acknowledged the service is going through a transitional period with the recent introduction of an electronic record system and a new manager, therefore some processes were not yet embedded. On our return to the service for day two of the inspection, the team were in the process of updating people's care plans and revising systems to ensure potential risks to people's health would be identified. These changes would ensure the manager had effective oversight of people's care and provide assurances staff were delivering care in line with people's needs.

- Relatives told us they were aware the service had a new manager, but they had not yet had any correspondence from them or received an introduction. This was raised with the manager who acknowledged this feedback. The manager explained that once the home reopened following the current closure due to COVID-19, relatives would be sent an introductory email and weekly activity plan with updates about what was happening in the home. The manager said they would also be inviting relatives to the service for a 'meet and greet', which would provide opportunity for relatives to meet the manager in person and ask any questions they may have.
- Managers and staff were clear about their roles and responsibilities. The team were motivated to provide

safe care and had confidence in the new manager to drive the improvements required within the service. One staff member told us of a time they approached the manager with a question about a person's care. They said, "I had a query about a new resident and it was dealt with. [Manager] listened and we worked out a good way of helping the resident, things have improved greatly." People and their relatives described staff as, "Respectful, warm and kind"; our observations confirmed this.

- Staff received regular supervision and felt supported by the management team. Staff received feedback on their practice and had opportunities to develop. Issues of performance were addressed and reviewed to ensure staff were competent in their role. One staff member said, "What is good about [manager] is if they think you are good at something, they will push you to do it."
- Staff felt the managers were approachable and promoted the provider's values of happiness, wellness and kindness throughout team. One staff member told us, "[Manager] is a great manager, I can approach them." Another said, "The [manager and deputy manager] are amazing, I feel listened to and they are approachable. I couldn't wish for a better manager. I have not felt so welcomed in that managers office before."
- The manager understood the importance of their role and was supported by the provider; they had regular contact with the senior management team. Legal requirements were understood, and the manager reported issues to the appropriate organisations, including CQC and the local authority.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The managers and staff promoted a positive, person-centred culture which was evident throughout the inspection. People and most relatives felt involved in their care and spoke positively of their experience of care provided. Comments included, "They [staff] seem to understand dementia well", and, "It's a lovely home. It's warm, welcoming, my [person] is well cared for, staff are kind and they seem well looked after." People were complimentary about the activities and support available. One person told us, "I have a go at everything they do, I do like singing. I like to sing and dance, I love dancing. They play some lovely songs."
- Staff told us the new manager had made a positive impact on staff morale and had an open and inclusive approach. One staff member said, "It was a shock when they started, they wanted to change their desk for a table and chairs so staff could sit and talk to them. They have changed a lot in the home already and all of us [staff] are much happier."
- The service worked in partnership with others including the local authority and clinical commissioning group (CCG). The team had enlisted support from multiple external agencies and acted on feedback to raise the standard of people's care. People had access to a range of health and care professionals including community and district nursing teams, GP, pharmacy and other specialist services to ensure people's health needs were continually assessed. We observed evidence of outward referrals to health professionals, and staff engaging with health professionals when they contacted the service to discuss people's 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; Continuous learning and improving care

- The manager understood their responsibilities under the Duty of Candour and was open and transparent when people's care had not gone according to plan. The manager had notified CQC of accidents and incidents that had occurred, and any lessons learnt or actions taken.
- When the previous registered manager left, the provider had quickly appointed the current manager to ensure there was ongoing managerial oversight of the home and care people received. The manager had made some changes to the day to day running of the service which had already begun to improve people's care and overall governance of the home. For example, adjustments to the skill mix and deployment of staff had increased the amount of time nurses had to provide care for people.
- The management team were committed to continuous learning and improving care. Accidents and

incidents were analysed, and when required actions taken to improve. The manager had identified areas for improvement and added these to the home's service development plan which was regularly reviewed. Some staff had been assigned lead roles to improve the oversight of specific areas within the home such as medicines and infection control. Staff told us if they suggested an improvement this was quickly actioned. One staff member said, "I asked for extra shelves for my COSHH cupboard, so it is safe, [manager] has a workman coming in for this."

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

- People were supported to give feedback about the service through residents' meetings, one-to-one sessions with staff and service user questionnaires. Most people's relatives told us they received updates about the home via email and calls. One relative said, "The home would phone or email me if something was wrong with [person]. COVID regulations were regularly emailed out which was quite useful. There have been questionnaires sent out as well."
- Staff felt part of a team and told us they were kept updated about changes in the service. One staff member said, "The best thing about the company are the people that work here, they are very good, the team are brilliant. We get weekly emails or if things have changed, we know what is expected of us and you are kept informed." Staff said they felt able to make suggestions to improve the service and running of the home. One staff member told us, "I haven't made any suggestions yet, but if there was anything, I tell the team leader who will go to [manager]. If it was something to be done there and then I would go to them myself."