Anchor Hanover Group

Buckingham Lodge

Inspection report

Culpepper Close
Aylesbury
HP19 9DU

Tel: 03001237243
Website: www.anchor.org.uk

Date of inspection visit:
27 April 2022
28 April 2022

Date of publication:
25 May 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Buckingham Lodge is a residential care home providing the regulated activity accommodation for persons who require nursing or personal care to up to 64 people. The service provides support to older people and people with dementia. At the time of our inspection there were 30 people using the service.

Buckingham Lodge is purpose built and accommodates people over three floors. Each unit has its own lounge, kitchenette, dining areas and bathrooms. Alongside this the service has a cinema room, hairdressers and family room. The ground floor unit provides care to people living with dementia, whilst the first floor supports people with residential and dementia care needs. At the time of the inspection two units were in use.

People's experience of using this service and what we found
People and their relatives were generally happy with the care. They told us staffing levels and communication with them had improved, although there was still some inconsistencies in staff due to agency use and access to activities for people. People and relatives commented "I am happy living here, the carers are all very nice and always very helpful," and "I am really pleased with Buckingham Lodge and can't speak highly enough of mum's care, it is second to none and the carers are all good."

Risk to people were identified and mitigated, with staff aware of people's risks and how to support them. Systems were in place to safeguard people. However, infection control practices observed did not always mitigate the risks of cross infection. A recommendation has been made to improve practices.

Staff were suitably recruited with training and supervision of staff improved. The provider had been proactive in recruiting staff to provide consistent care to people. Staffing levels had improved with an isolated occasion where the staffing deemed required was not provided due to short notice sickness.

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. Improvements have been made with decision specific mental capacity assessments and best interest decisions in place. However, we have made a recommendation for the provider to work to best practice in their application of the Mental Capacity Act 2005 and ensure mental capacity assessments and best interest decisions are referred to in relation to the delivery of care.

Staff meeting minutes and email communication with relatives indicated that the service did not encourage negative feedback. This did not promote an open and honest culture to promote positive outcomes for people. We have made a recommendation to address this.

Auditing and monitoring of the service was taking place which enabled the provider to identify shortfalls in the service provided. Improvements have been made to records, however we have recommended further

improvements to ensure records are suitably maintained.

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 15 September 2021) and there were breaches of regulations. 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 regulations.

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

Why we inspected
We carried out an unannounced focused inspection of this service on 15 and 16 June 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding, staffing, good governance and need for consent.

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

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

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.

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

Recommendations
We have made recommendations under safe and well led to further improve practice and sustain improvements.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Buckingham Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors on both days and an Expert by Experience on day two. 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
Buckingham Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Buckingham Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection a manager had been appointed and had applied to CQC to be registered.

Notice of inspection
This inspection was unannounced.

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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with five staff which included the manager, acting regional manager, deputy manager, a team leader, the wellness coordinator and had informal conversations with two carers.

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 and we carried out some other general observations at lunchtimes on both days.

We reviewed the environment and a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and four other staff files in relation to training and supervision. We reviewed a sample of health and safety records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas, allocation records, audits, meeting minutes, fire records, policies and procedures.

We spoke with six relatives and seven staff, which included the manager. We received written feedback from one relative. We requested feedback from health professionals involved with the service. None was received.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection people were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to safeguard people. The provider had safeguarding policies in place and staff were trained in safeguarding. There was a mixed response to staff's understanding of safeguarding, although staff spoken with confirmed they would report concerns to management, the Local Authority or the Care Quality Commission.
● People told us they felt safe. People commented "Yes, of course, I feel safe all the time. The carers are all very nice and they endeavour to be understanding," "I use my buzzer if I need help, someone always comes," and "Oh yes, I'm safe, you have only got to ring the bell, someone always comes. They respond quite quickly to the buzzers." One person told us that a care worker shouted at them sometimes. They commented "She shouted at me last night, I felt anxious, but I expect they all think I can be a bit of a nuisance sometimes." This was fed back to the manager to investigate and act on.
● Relatives confirmed they felt confident their family member received safe care. Relatives commented "Mum is 110% safe, completely safe. If there are any minor problems they are addressed very quickly," "Safe, I do think she is safe. They have been very good with her and she has a good rapport with the carers."
● In a person's file it was noted that they had made an allegation of "being pushed". There was no indication this had been reported, escalated or investigated. In response to our feedback the provider investigated the allegations. They confirmed that their investigation concluded the person was referring to being 'rushed' rather than 'pushed'. They assured us the staff member who had incorrectly recorded the interaction and team leader on that shift were spoken with to ensure people were safeguarded.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

At our last inspection people were not consulted with in relation to consent to care. This is a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found certain areas required further attention.

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● People's care plans contained detailed decision specific mental capacity and best interest decisions for people who required them in relation to aspect of their care, such as living at the service, medicine administration including administration of covert medicines, use of sensor mats, vaccines and key pads.
● Mental capacity assessments and best interest decisions for COVID -19 testing had been completed however, they were archived despite the home having a COVID -19 outbreak at the time of the inspection. On day two of the inspection whole home testing was carried out without reference to those mental capacity assessments and best interest decisions. This meant staff had not assured themselves that for people who lacked capacity, the decision to carry out the testing was in their best interest. In response to feedback on the inspection the provider confirmed the mental capacity assessments and best interest decisions for COVID -19 testing was put back on people's files. In two care plans viewed they had mental capacity assessments and best interest decisions for checking them every two hours at night with the rationale for that decision being that the person might get disorientated or miss meals. However, we were not assured that the rationale for the two hourly checks evidenced it was in the person's best interest. The provider confirmed the organisations care quality advisor continued to work alongside and support staff to embed their understanding to enable them to work to the principles of the Mental Capacity Act 2005.

It is recommended the provider works to best practice in relation to the application of the Mental Capacity Act 2005.

Preventing and controlling infection
At our last inspection Infection control risks were not always mitigated. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found certain areas required further attention.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. During the inspection we observed a staff member carry laundry from a bathroom without it being in a bag and without them wearing any PPE. At the end of the inspection whole home testing was taking place. A staff member carried a red bag from a bedroom of a person whom had tested positive through the service to the sluice area. Alongside, this some people had their Covid-19 testing carried out in the lounge and all of the completed antigen tests, including those that were positive were lined up on the

trolley and later on the reception desk to be inputted into the computer. There was no oversight of the testing with several staff involved in the process. PPE was not changed in between tests and not all staff wore full PPE whilst setting up PPE stations outside bedroom doors of people who had tested positive, with staff in and out of those bedrooms and then not changing all of their PP. Staff meeting minutes and 10 at 10 meeting minutes showed staff were constantly reminded of the importance of wearing PPE correctly and infection control practices. After the inspection the manager confirmed the outbreak was contained and the infection control concerns identified at the inspection were addressed with individual staff and team leaders.

● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were in place, including cleaning records for high touch areas. We observed a build-up of dirt and food down the sides of fridges and dishwashers. The walls and skirting around the bin areas in the kitchenettes were stained with food and drink splashes and the carpets and armchairs on the ground floor were badly stained. The provider confirmed in response to the feedback at the inspection that this was rectified immediately, and heads of departments reminded to ensure this was maintained.

It is recommended the provider works to best practice to mitigate cross infection risks.

● We were assured that the provider was preventing visitors from catching and spreading infections. On arrival at the home we were required to show our lateral flow test results and complete a screening questionnaire.
● 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.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Visiting in care homes
At the time of the inspection the service was in outbreak. People were allowed one named visitor and those visits were taking place.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Risks to people were identified and mitigated. People's care plans had been developed since the previous inspection and were person centred. Risks associated with medical conditions such as diabetes, use of anticoagulants (Medicines that help prevent blood clots), flammable creams, and tissue viability were addressed.
● In one file viewed it was identified the person was at risk of choking. This was a known risk and the service had consulted with the Speech and Language therapist to mitigate the risk. There was no recorded risk

assessment on their file to outline the risk and management plan, however staff spoken with were aware of the risk and aware of the meal type and positioning required at mealtimes. Following our feedback, a choking risk assessment was put in place to further mitigate the risk.

● During the inspection we observed a flicking light in the corridor which had the potential to trigger seizures for people with epilepsy. The service had a contractor in the service fixing the lighting which had caused the light to flicker. This was pointed out to the manager on day one of the inspection and addressed on day two of the inspection.

● The service was responsive to changes in people's health to mitigate risks. They referred on to health professionals in a timely manner to promote regular reviews of people's changing needs. Relatives told us they were updated following GP visits. A relative told us how well the service supported their family member following a hospital admission, whilst other relatives told us the staff needed reminding to clean their family members teeth, wash hair and keep their nails clean and cut. This was fed back to the manager to monitor.

● Health and safety checks took place which included fire safety, window restrictors, water temperature and carbon monoxide checks. Legionella testing was completed and equipment such as the lift, fire equipment, gas, electricity and hoists were serviced. An up to date fire risk assessment was in place. People had personal emergency evacuation plans (PEEPs) on file and records viewed showed fire drills took place, which were used as fire safety training for staff. People told us there was a delay in equipment being repaired and the garden was overgrown and inaccessible. This was fed back to the manager to address.

Using medicines safely

●Systems were in place to promote safe medicine practices. The provider had a medicine administration policy in place and staff involved in medicine administration were trained and had their competencies assessed to administer medicines.

● Medicines were suitably stored and at the recommended temperature. A record was maintained of medicines ordered, received, administered and disposed of. Interim prescriptions where handwritten, included two staff signatures.

● Protocols were in place for "as required" medicines and an approved homely remedy list was in use. There was a delay in the delivery of monthly supplies of medicines which the service was addressing with the supplying pharmacy.

● The medicine administration records viewed showed medicine was given as prescribed, except for a person's topical cream which was not recorded on the medicine administration records and the topical administration record did not indicate it was applied at the frequency outlined by the district nurse. This was immediately addressed.

● A person's prescribed risperidone ran out of stock on the 15 April 2022, even though a month's supply had been provided. This was not investigated or escalated to management until pointed out at the inspection. The provider confirmed after the inspection the medicine had been wrongly returned to the pharmacy and the person missed one dose, which did not have a detrimental impact on them. However, they agreed to have a supervision with the staff member involved to reinforce procedures to prevent reoccurrence.

● During the inspection we observed medicine being administered. A "do not disturb" tabard was not worn by the staff member administering medicine. We were told a decision had been made not to wear it as people tended to distract staff more when worn. However, there was no risk assessment around the decision. Later that day the decision was revoked, and staff wore the tabard during medicine administration. The provider confirmed in response to the feedback from the inspection the service is looking at other tabard colours that may alleviate people's anxiety. Episodes of distress at medicine administration times will be monitored with staff informed to distract and record episodes of distress to mitigate risks.

Staffing and recruitment

At our last inspection sufficient numbers of suitably qualified, competent, skilled and experienced staff were

not always provided to provide safe and consistent care to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider confirmed the core staffing levels per shift based on people's dependency levels and the current occupancy at the service. Two team leaders and four care staff were required on the morning and afternoon shifts, with management available to assist on the morning shift during the week. One team leader and four care staff were required at night.
● Prior to the inspection we had received whistleblowing information that staffing was not sufficient, especially on the ground floor and it had identified the 15 April 2022 as a date where the service was short staffed. On the second day of the inspection we received further whistle blowing information which alleged the service was short staffed at the weekends.
● The rotas and shift planners reviewed from 28 March till the 1 May 2022 showed staffing levels were generally maintained with the provider overstaffing over the core amount of staff required. There were some shifts where there was only one team leader on shift, but the care staff numbers increased on those occasions, except for the 23 April 2022 where only one team leader was on shift with four carers. There was a delay in informing the on-call manager, which was addressed to prevent reoccurrence.
● People gave us mixed feedback on the staffing. They commented "The number of carers here are about right I think," "Sometimes I think that there are not enough staff but those that there are , they are very nice, I find them sympathetic on the whole but they are always very busy," and "I think they could do with a few more, certainly more permanent staff, not agency because you need the same staff that know what they are doing." They added "I think they should keep the same staff on the same landing but they all keep swapping over, some are on mornings here, then afternoons, then all day and then they are off for a while, so there is no consistency."
● Relatives told us staffing and activities had improved, although still not always sufficient with very little one to one activities provided. Relatives commented "Things appear to have improved a bit recently with less over reliance on agency numbers," "Generally we think there are enough staff. If I ask to speak with a team leader, they always come. At weekends it is more difficult to phone the home, the calls are not usually answered as they do not have reception staff at the weekends;" "The weekends are absolutely hopeless, there are no activities and no one appears to be taking an interest in {family member]," and "Turnover of staff seem high and at times there is not enough staff on duty, with calls for help ignored for quite a while."
● The provider continued to recruit into staff vacancies and agency staff were used to cover gaps in the rota although, there was less reliance on agency staff now compared to the previous inspection. Staff told us there was occasions where they were short staffed, but that generally team leaders and management help out. Other staff indicated some team leaders were unwilling to help on shift and just do the medicines and care plans. This was fedback to the provider who confirmed they were aware, and it was being addressed.
● Care staff were responsible for facilitating activities, under the direction of the organisation's wellness coordinator. Activities took place to celebrate events such as pancake day, Mother's Day and Easter. Alongside this, in-house activities such as singalongs, art and crafts, movie nights and floristry took place. Staff told us when staffing is pressured activities do not happen and that it is always the same staff who facilitate activities. The wellness coordinator told us they recognise there is still work to do to improve the activities on offer. They advised welfare officers had recently been recruited to further support activities.
● At the previous inspection staff were not suitably trained and supported in roles. At this inspection the training statistics showed the total training for the service was 92% with new staff enrolled on the care certificate training and staff offered training suitable to their roles such as dementia awareness, medicine

management and moving and handling. Some relatives did not feel some of the younger staff had the skills to support their relative. Relatives commented "You often see some carers, a lot of them are very sweet with their interactions but youthful ones do not necessarily know all about older generations," and " I am not completely confident in some of the younger staff being able to deal with some situations, for example falls and aggression."

● Staff told us they felt suitably trained for their roles and new staff confirmed they shadowed other experienced staff. Staff told us they had access to regular training and the quality of the training had improved.

● Staff confirmed they received supervision, although the frequency of that varied for staff. The supervision matrix provided showed the frequency of supervision of staff had increased with most staff having had a supervision, except for night staff. The provider was made aware of this to follow up on it.

At our last inspection we had recommended the service works to best practice and their own recruitment policy to ensure staff are suitably and safety recruited.

●Systems were in place to promote safe recruitment practices. Staff had two references on file and Disclosure and Barring Service (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. A photo and health questionnaire were on file and gaps in work histories explored.

● As part of the recruitment process candidate's complete literacy and numeracy tests. However, we found that as part of the interview process the forms around scoring had not been filled out and only one out of four had completed the literacy and numeracy test. The provider confirmed they would provide further training to staff involved in interviews to ensure these tests were completed in line with their recruitment policy.

Learning lessons when things go wrong

● The provider had systems in place to promote learning when things went wrong. Lessons learnt documents are completed following an incident. These are reviewed by the management and then shared with the whole team, so that that they are aware of the lessons learnt and the actions needed to minimise the risk of recurrence.

● Alongside this the organisation had a system in place, which captures events including accident and incidents, safeguarding's, serious untoward incidents, complaints and falls. This bespoke system is overseen by home managers, district managers, directors of care, care quality team and governance and safeguarding team. The system captures the incident and provides an overview of the incident progress and any lessons learnt. Safeguarding concerns reported on the system are reviewed by the governance and safeguarding team who are responsible for ensuring that any incidents closed at a local level have the appropriate information captured. A monthly report is provided which highlights any emerging themes and trends in relation risk management and oversight.

● Staff at the service have access to a serious untoward incident 'on call' team who triage any incidents reported through the event capture system. This ensured support and guidance can be provided in a timely manner to effectively manage the incident and risks.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection good governance was not established, and the service was not suitably managed to provide good outcomes for people. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found certain areas required further attention.

● Team meeting minutes viewed did not promote an open culture. Whistleblowing was discouraged and staff were told to report positively to the Care Quality Commission and the local authority. It indicated staff who reflected the service in a bad light would be reported back to the manager. A staff member told us they did not feel able to raise concerns and commented "I would be worried to raise something, as everyone finds out who it is."
● In email communication from the service to relatives to inform them of the opportunity to provide us with feedback, they were instructed to share any negative feedback about the care with the management of the home as opposed to CQC.
● The provider had policies in place to support the manager to promote an open and inclusive culture. During discussion with the manager after the inspection they reassured us that they are open and receptive to feedback and the team meeting minutes did not reflect an accurate record of the discussion. The minutes of a more recent team meeting minutes reminded staff of the whistle blowing policy and for them to feel empowered to use it, which the manager felt reinforced they promoted an open culture of reporting.

It is recommended the provider works to best practice to embed an open culture to provide good outcomes for people.

● Since the previous inspection a new manager had been appointed and they commenced working at the service in February 2022. They had applied to the Commission to be registered, with their fit person interview scheduled for later in May. Their vision for the service was to improve care to people, with the quality of the service at the heart of everything they do.
● Team meeting minutes showed discussions with staff around promoting person centred care, equality,

diversity and inclusivity to promote individual's protected characteristics.
● We received mixed feedback on the management of the service. The manager had moved their office downstairs as they wanted to have a visible presence in the home to enable them to be accessible to people, staff and relatives. Some staff felt there was more of a management presence with management being approachable and accessible. Staff felt well supported when managers were on call. Other staff indicated management do check on them but do not work on the floors with them. From the allocation records viewed we saw the deputy manager assisted on occasional shifts, although the rota did not reflect that.
● Staff commented "I feel like there has been improvements, there were staff who were set in their ways, unhealthy habits that needed to be broken and the manager dealt with it appropriately," and "Yes, going in the right direction, care side taking steps in right direction and staff are pulled up for not doing things right."
● People confirmed they had met the new manager and felt able to raise issues with them and staff. Relatives had been informed and introduced to the new manager, but some told us it was too soon to be able to comment on their management approach. However, relatives felt communication had improved and some stability had been delivered. Relatives commented "There does now seem more focus on communication and managing situations that arise;" and "It is nice to have [managers name] on board, I feel he will do well."

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

At our last inspection records were not fit for purpose, systems and processes were not established, operated effectively and audited to ensure the delivery of high-quality care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found certain areas required further attention.

● Improvements were made to record management and in general we found people's care plans were reflective of their needs and risks. However, we found a person's care plan was contradictory as to whether the person had capacity or not with a relative asked to consent to the vaccine for their family member as opposed to involving the person and a person's moving and handling plan contradicted their hoist transfer plan. The provider confirmed in response to our feedback that those contradictions in care plans were addressed.
● The staff rota and allocation sheet were not always suitably maintained to ensure it was reflective of the staff on duty. It did not reflect the shifts management assisted on and agency names and shifts were not always legible to be assured which staff were on duty.
● The provider was aware of their responsibilities to make notifications to us in respect of safeguarding, serious incidents and events which stop the service running. However, a notification was completed in retrospect of safe staffing levels, only after the concerns around the shift been short staffed were raised with them from information we had received.

It is recommended the provider works to best practice to improve records to ensure they address shortfalls in a timely manner.

● Systems were in place to audit and monitor the service. A series of in-house audits took place which included audits of medicines, care plans, infection control, health and safety, catering and observation of

dining room experience for people. Alongside this the provider audited the service with an inspection type audit carried out in March 2022 which included a review of records, the environment and feedback from staff and relatives. The audits identified areas for improvements which were included in the home's action plan and were being addressed and reviewed.
● Staff told us they were clear of their role and responsibilities and they felt suitably trained and supported. During the inspection we observed positive engagements with people which promoted people's dignity and respect.

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

At our last inspection good governance was not established to engage with people, relatives, staff and to promote continuous learning to improve care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had systems in place to gain feedback on the service. A staff survey was completed in October 2021. The service had recently sought feedback from relatives around the care provided, with positive feedback received. Alongside, this the service had an ongoing improvement plan for engagement and resident wellbeing. As part of this the manager sent out a survey to the families for their feedback on activities with the responses still being collated. Monthly zoom meetings were taking place with relatives to keep them updated and informed of what was happening in the service. Relatives told us they were able to access the homes Facebook page to see what activities had taken place.
● People were encouraged to contribute to the activity programme. In March 2022 staff had completed likes and dislikes sheets with people to improve and personalise the activities for them. The results and choices were collated, and the most popular activities were added to the events calendar.
● Systems were in place to promote communication within the team. Daily handovers, 10 at 10 meetings, monthly team meetings and health and safety meetings took place. Staff felt communication had improved. They commented "[managers name] and [deputy managers name] have not been in post long, but they all communicate well together with staff and team leaders;" and "I like that there is staff meetings regularly, which has improved communication."

Continuous learning and improving care
● The service had improved opportunities for learning with the providers care quality advisor working alongside staff in the delivery and application of training.
● The provider and management had worked with staff to improve care and systems were in place to enable them to monitor and review the service provided.

Working in partnership with others
● Records showed the service worked closely with health professionals involved in the service. Feedback was requested from health professionals as part of this inspection however, none was received.
● External entertainers and animal visits to the service were taking place with positive feedback from people about the benefits of the visiting farms. One person told us they had gone out shopping with a staff member which they had enjoyed, and people told us that they had recent discussions about more trips out to places such as garden centres and the zoo.
● The service had set up a pen pals project with a local primary school and on a monthly basis they held a

snacks and refreshment stall for the children. During school terms people were supported to wave to the local school children as they walked past. During the inspection we observed people involved in this activity with enthusiasm.

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 provider had a duty of candour policy in place which indicated a face to face meeting should be offered with the person and/or their relative and this should be followed up with a written explanation and apology following a safety incident.
- A notification sent to us indicated the duty of candour was applied. This was reviewed and found to meet the regulation.