

St Philips Care Limited

Tunstall Hall Care Centre

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Tunstall Hall Care Centre is a care home without nursing care. The home accommodates a maximum of 31 people in one large building and two separate bungalows. At the time of our inspection 29 people lived in the home, some of whom were living with dementia. Care was provided over three floors. On the ground floor there were large communal rooms, including a lounge, dining room and a library for people to enjoy. Bedrooms were located on the first and second floor, a lift was accessible to each floor. There were large gardens surrounding the home.

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

We found risks to people were not always assessed, managed or monitored safely. People's medicines were not always stored or administered in a safe way. Medicine stocks were not closely monitored. Risk assessments were not always completed for people's specific risks and people's weights were not always adequately monitored in line their care and support plan. Some items, which could cause significant harm if ingested, were stored in rooms where the key was located on the wall next to the locked door.

Infection prevention control policies were not always followed regarding safe hand care practices and COVID-19 safe visiting practice.

The registered managers carried out quality assurance processes, including internal audits. However, these were not always effective in identifying the concerns we identified. This meant errors were missed which could potentially cause harm.

Notifications involving safeguarding were not always reported to us, in line with regulatory responsibility.

Concerns identified on the first day of inspection which could have been actioned were found again on the second day.

During the inspection there was a COVID-19 outbreak. Most people had chosen to self-isolate in their rooms. Staff told us how they felt rushed and under pressure to support people individually in their bedrooms.

The registered manager addressed all concerns identified and put in additional measures and systems to keep people safe from harm. We will review these in the next inspection.

People felt safe living at the home and with the staff who supported them.

Staff were recruited safely, they received a detailed induction and ongoing training.

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. Staff gained consent from people before assisting them and respected their privacy.

Staff used personal protective equipment (PPE) effectively and had attended infection prevention control training.

People's communication needs were assessed, and people were supported to maintain relationships with others.

People told us they received care from kind and compassionate staff members.

People and relatives told us the food was well prepared and there were numerous activities for people to enjoy.

Relatives told us they felt their family members received person-centred care. They said staff respected people's dignity and encouraged people to be independent.

Accident and incident forms were investigated by the management team. Lessons learnt were shared with the staff team.

End of life care plans were detailed and included people's preferences and wishes.

Staff told us they received regular supervisions and took part in regular team meetings.

The provider worked with other health and social care organisations to improve care and support for people using the service.

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 20 December 2018).

Why we inspected

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. The provider took effective action to mitigate some of the risks during the inspection.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the way people's risks were assessed and monitored, medicines management, and governance systems at this inspection.

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

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

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 ●

Tunstall Hall Care Centre

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.

Inspection team

This 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

Tunstall Hall Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Tunstall Hall Care Centre 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 there was a registered manager in post.

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 professionals who work with the service. We 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

During the inspection we spoke with two people who used the service and ten relatives about their experience of the care provided. We spoke with 11 members of staff, this included senior staff, care support staff, cook, domestic staff and activity coordinators. In addition, we with spoke with the registered manager and the deputy manager. We reviewed a range of records. This included five people's care records and multiple medication records.

We looked at three staff files in relation to recruitment and staff supervision. In addition, we reviewed a variety of records relating to the management of the service, including policies and procedures.

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 good. 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.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Risks to people were not always assessed or mitigated. Risk assessments detailing how to respond to people's specific behaviours and specific health conditions such as diabetes, Parkinson's disease, catheter care were not always in place. Although, staff had good knowledge about risks to people and told us how they supported people safely.
- Some people were at risk of losing weight. These people's care plans clearly showed how they needed to have their weights monitored on a weekly or monthly basis, depending on their individual risk of weight loss. There were numerous gaps in the monitoring of people's weights without explanation. The registered manager told us there had been faults with equipment and the charger for the weighing equipment had repeatedly gone missing. However, there had not been any other attempt to monitor weight or body mass index (BMI) in these periods.
- The sluice rooms on the first and second floor were locked. However, the key was located hanging on the wall next to the locked door. The sluice room is a room where laundry is carried out and cleaning products stored. These rooms were often unsupervised. This meant people could access cleaning products, which could be harmful to them, without the knowledge of staff. We informed the registered manager. On the second day of inspection the key was still hanging on the wall next to the sluice room doors.
- Medicines were not always managed safely. We found one person did not receive medicines for two days as their medicine stock had run out. While contact had been made with the GP to advise the medicine was not in place, no further health professional contact had occurred to discuss the risks posed from the person's missed medicines. On the second day of inspection the medicine was back in stock.
- Medicines were not always stored safely. We found the area where a locked medicine trolley was stored was not having ambient room temperature monitored. This meant the temperature where medicine was stored may exceed safe manufacturer's guidance levels which could result in medicines deteriorating or not being safe and effective to use.
- An effective system to record pain relief patch use was not in place. We found some people received pain relief via patches but were not assured the manufacturers guidance to rotate where the patches were placed was followed. Failure to carry out patch rotation can result in skin irritation and may impact the absorption of the medication. This meant people may have experienced unnecessary pain.
- People were offered and received pain relief medication. There were clear protocols advising staff what signs and symptoms to be aware of when people were experiencing pain. However, not all staff knew where these were located or how to access them. This posed a potential risk in staff not administering medication in line with health professional's guidance.
- We were not assured the provider was preventing visitors from catching and spreading infections. During

the inspection, the care home was experiencing an outbreak of COVID-19. Upon arrival, we were not asked for evidence we had carried out a rapid lateral flow test (LFT), in line with current government guidance. We informed the registered manager. On the second day of inspection we were again not asked for results of an LFT test.

- On the first day of the inspection, a staff member told us how one member of the management team was not following their hand safety protocols outlined in the providers infection control policy. They were wearing nail varnish. The staff member felt the management team should lead by example. We raised this with the registered manager. On the second day of inspection, the same staff member continued to wear nail varnish. The registered manager explained this staff member was completing administration duties. However, should an emergency occur the staff member would not be able to safely respond.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection to make improvements and mitigate risks to people. Risk assessments relating to people's health conditions and specific behaviors were completed, these were shared with the staff team. Additional weight equipment has been ordered and staff have been reminded to record the reason if a person was not weighed. Key's have been removed from the wall next to the sluice room doors. The registered manager told us they will be installing keypad locks. New systems were introduced for monitoring medicine stock levels, pain relief protocol's and patch location. The medicine trolley was also relocated. We will assess these new systems in our next inspection, and we will ensure all infection control policies are being followed.

- Personal evacuations plans were in place. Each person had a personal evacuation plan regarding how they would need to be safely supported in the event of a fire. This meant staff were aware of what to do to keep people safe if an emergency occurred.
- Staff received medicine administration training. One staff member said, "I am doing my medication administration course at the moment, it's really good. I will then be able to administer medication safely."
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- 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 responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. One relative told us, "Oh yes, the home is very clean and well maintained."
- 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 have also signposted the provider to resources to develop their approach.

Visiting in care homes

- The provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

- Staff felt rushed. During the inspection there was a COVID-19 outbreak. People were choosing to self-

isolate in their rooms. This placed extra pressure on the staff team to support each person individually. Staff appeared rushed and found it difficult to stop and talk. One staff member said, "There are not enough staff on duty, especially with people isolating in their rooms." The registered manager responded by introducing a COVID-19 outbreak staffing risk assessment which resulted in an additional staff member being added to the shift.

- People sometimes waited long times for call bells to be answered. On one occasion, a person waited over 17 minutes for the call bell to be answered. The inspector alerted a member of staff to the call and checked on the individual concerned. The registered manager responded by implementing call bell monitoring systems and increasing staff support during a COVID-19 outbreak. Due to call bells not being monitored when there was not an outbreak, we could not tell whether this was a regular occurrence.
- We received mixed feedback from staff regarding staffing levels outside of an outbreak of COVID-19. Some staff said there was enough staff on duty. Others told us more staff or management support on the floor was needed. Most staff said if there was an emergency, they felt rushed and under pressure. Relatives felt there was enough staff available when they visited the home. One relative said, "Oh yes, I have never noticed a situation where there are not enough staff."
- Staff rotas were in place and the management used a staffing dependency tool. A dependency tool can help a provider identify how many staff members are needed each day and time. Although this needed updating in light of COVID-19 outbreaks.
- Staff were recruited safely. Recruitment files showed all pre-employment checks had been made to ensure only staff who were suitable to work with people were employed.

Systems and processes to safeguard people from the risk of abuse

- Relatives felt their family members were safe in the home. One relative said, "Oh yes, [my family member] is very safe". Another relative said, "[My family member] does not want to be moved. They are safe and happy."
- Staff received safeguarding training and had access to relevant policies and guidance. One staff member told us, "The safeguarding policies are in the office or you can access them online."
- Staff understood what was meant by abuse and they were confident about how to report safeguarding concerns. One staff member said, "If I saw someone doing something they shouldn't be doing. I would pass it on to the manager straight away."

Learning lessons when things go wrong

- Areas of improvement identified within this inspection were acted upon and new systems implemented. These new systems will be reviewed in the next inspection.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the staff team creating a culture of openness when things went wrong.

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- Relatives told us people's choices were promoted. One relative said, "They always ask my [family member] if they want to go into the chair. They ask if they would like lunch. My [family member] feels involved and the staff are always talking to them."
- Staff knew people well and how best to meet their individual needs. Staff told us about people's care, likes and dislikes.
- Support plans set out current needs, promoted strategies to enhance wellbeing and to meet people's goals. One person identified with a particular religion but struggled with mobility. The plan identified how the person was supported to attend the weekly worship meetings remotely using an iPad. This helped to promote the person's wellbeing.

Staff support: induction, training, skills and experience

- Staff received a comprehensive induction and on-going training. One staff member said, "There is enough training, it is good." Another staff member told us, "During induction, they showed me what to do and I could always go back to them with questions. They showed me how I can read the care plans and find out about people's support needs."
- Staff told us there were regular staff meetings and one to one supervision. We saw supervision timetables and minutes of team meetings.
- Staff received support from management if they felt unsure about putting their training into practice. One staff member told us, "Moving and handling training was good, but I was a little nervous to start with. They gave me extra training." This helped to ensure staff had the relevant skills and knowledge to carry out their roles.

Supporting people to eat and drink enough to maintain a balanced diet

- People and relatives felt the food prepared was of a high standard and promoted choice. One person told us, "The food is okay here. It is cooked well." One relative told us, "The food is very good. My [family member] requires assistance to eat and they support them. The quality of the food is good. They know what my [family member] likes to eat." Another relative said, "My [family member] likes the food. We are quite envious; it always looks good."
- Due to people choosing to isolate in their own rooms we could not observe the mealtime experience. We did observe the food being served to people in their rooms. It looked and smelt appetising.
- The kitchen staff had detailed knowledge of people's needs. Meals were prepared to meet people's dietary requirements. Some were pureed for people who experienced swallowing difficulties, other were fortified for people who were at risk of malnutrition. Fortified foods have added vitamins and minerals to improve

nutrition and health benefits.

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

- People's health needs were regularly assessed and reviewed. The records showed staff followed the recommendations made by healthcare professionals.
- The provider had recently started a new initiative to improve oral health in the home. Two staff members were due to attend a course and then pass this knowledge to the rest of the team.

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

- People's care and support was provided in a clean, well-furnished and well-maintained environment which met people's physical needs.
- There were signs on people's doors. However, we could not locate many dementia friendly aids, such as large clocks displaying the month, date and weather or pictorial signs pointing people to communal rooms or the lift. The registered manager told us they will be completing a dementia friendly audit to highlight improvements to the home.
- People personalised their rooms and were included in decisions relating to the interior decoration and design of their home. One person told us about the personal items in their room and told us how they related to their lives. This helped the person feel at home and emotionally connected to their room.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff confirmed they had attended Mental Capacity and DoLS. A training matrix confirmed this training had taken place.
- Assessments of people's mental capacity and best interest meetings had taken place to ensure decisions made were appropriate and least restrictive. This related to the decisions concerning where a person should live and personal care.
- The registered manager made appropriate DoLS applications for people who required this level of protection to keep them safe, they ensured the applications met the needs and conditions of the authorisation.
- Staff told us about the principles of Mental Capacity Act. One staff member said, "I had Mental Capacity training. It is important to continually assess capacity, especially if someone has fluctuating capacity. Sometimes you have to make best decisions for people." Another staff member told us about the

importance of gaining consent.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People felt valued by kind and compassionate staff. One person told us, "The staff are very good. I can't criticise any of them. They are excellent. They are spot on."
- Relatives felt the care was personalised. One relative told us, "The carers are kind, my [family member] is listened to. My [family member] sings their praise and they know all about the staff member's families and life." Another relative told us, "The staff are very professional and have a caring attitude."

Supporting people to express their views and be involved in making decisions about their care

- Relatives told us people were supported to make their own decisions. One relative told us, "My [family member] can get up when they want to. My [family member] has a key to their room; they have no restrictions. Their meals are at a set time, but if they want to, they could buy other food and eat it in their room."
- During the inspection we saw people choosing to self-isolate due to a COVID-19 outbreak. At one point, we saw a person leaving their room, they appeared disorientated and asked a staff member where everyone was. The staff member reassured the person sensitively and asked what they wanted to do. The person sat with the staff member for a while assisting them with their tasks before choosing to return to their room.
- People and relative meetings took place on a regular basis. We reviewed minutes of these meetings. These showed people expressing their views and making recommendations to the service. The recommendations were actioned by the registered manager.

Respecting and promoting people's privacy, dignity and independence

- Privacy and dignity were respected. Staff members always knocked on bedroom doors before entering and addressed people in their preferred names.
- Staff understood the importance of promoting independence. One staff member said, "It's really important to promote people's independence. If the person is still able to, I would give them a warm flannel or sponge and ask them to wash their face and hands. I could then wash their back and so on. Even promoting their choices by choosing what to wear for the day."
- Staff respected people's dignity. One staff member said, "If you are supporting someone with personal care, it's important to make sure the door is closed and always cover the person with a towel. It's how you would want to be treated."

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has remained good. 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

- Relatives felt care was person centred. One relative told us, "They support my [family member] to go shopping if they want to buy face cream, or to the post box." Another relative said, "My [family member] can have their hair done once a week and the chiropodist comes in regularly."
- People were supported to understand their rights and explore meaningful relationships. Care plans had detailed explanations of LGBTQ+. This initialism stands for lesbian, gay, bisexual, transgender, queer or questioning. The '+' represents those who are part of the community, but for whom LGBTQ does not accurately capture or reflect their identity.
- Staff understood people's needs and preferences. They spoke knowledgably about tailoring the level of support to individual's needs. This was good because it showed staff knew people well.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were assessed and recorded in their care plan. Hearing aids and spectacles were maintained in line with their care plan. We saw documentation of regular updates and visits to opticians.
- Staff had good awareness, skills and understanding of individual communication needs. We asked a staff member how best to communicate with a person. They said, "[The person] can communicate in their own way. You have to speak slowly and loudly as they are a little hard of hearing." This was corroborated in the care plan.
- People had access to talking books and large print reading materials to support people with sight difficulties. This was positive because it enabled people to continue to read without asking for assistance from others.

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 regularly participate in social and leisure interests. One person told us, "Activities are okay. There are enough things to do. I'm going for a walk later."
- One relative said, "My [family member] can go out when they want. They will get a taxi into the town and

can get a pint if they want to or go to the shops." This was good because it evidenced people had choice and control over their activities and could take their own risks.

- We saw photos of religious events and regular services. One relative told us, "A local Vicar comes in one Wednesday a month. My [family member] really enjoys this."

Improving care quality in response to complaints or concerns

- People and their relatives were able to complain. One relative told us about a concern they had raised over clothing belonging to someone else being left in their family members' room. They said this was resolved quickly. Staff supported people to raise concerns also.

- Concerns and complaints were dealt with. All concerns were investigated by the registered manager. Lessons learnt were shared with the whole team to ensure concerns did not happen again.

- Complaints were resolved. We reviewed a formal complaint to the provider which acknowledged concerns and apologised when things had gone wrong.

End of life care and support

- People who were nearing the end of their life, received compassionate and supportive care. The provider tried to gather last wishes from people near to the end of life and to see these through. There were some truly unique examples showing how the provider met people's final wishes. A staff member told us these moments were special for the person and their families.

- People's care plans contained end of life wishes and choices. We saw how the home used ReSPECT forms to gather people's wishes for end of life treatments. ReSPECT forms record a summary of a patient's wishes for emergency care and treatment.

- The service respected people's religious wishes during the end of their life. We saw examples of people receiving their chosen religious ceremonies, such as receiving 'Last Rites'. These are the last prayers given to an individual of Christian faith shortly before death.

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

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

- Checks and audits completed were not effective. We found while processes were in place, risks and areas of concern were not effectively identified. For example, quality monitoring systems had failed to identify people did not have specific health and behaviour risk assessments in place. Risks from the environment such as unsafe storage of cleaning products were also not identified.
- Systems had failed to identify the shortfalls we found in relation to medicine management and administration. For example, skin patch rotation and safe medication storage. People had not received their prescribed medicines and appropriate advice from healthcare professionals had not been sought in a timely manner. This exposed people to the risk of harm.
- Staffing levels during COVID-19 outbreaks had not been reviewed. There was enough staff to respond in a timely manner to call bells and to support people choosing to self-isolate in their room. Care staff told us they felt rushed and needed support during this period, especially during busy times such as medicine administration, supporting people to eat and meal delivery.
- Call bell waiting times were not being effectively monitored or audited. People waited long periods before being supported. This meant opportunities to ensure people received safe care and treatment were missed.
- Safeguarding referrals had been raised with the local authority. However, we had not been notified in line with regulatory responsibility. This meant we were unaware of the number of safeguarding referrals made to the local authority which may impact upon our monitoring and regulatory duties.
- Infection prevention control policies were not always being followed in relation to visitation and safe hand care. This could increase the risk of infection within the home.
- Risks identified during the inspection were not always actioned in a timely manner. On the first day of inspection, concerns relating to infection prevention control and safe storage of hazardous items were raised. These remained evident on the second day of inspection.

We found no evidence people had been harmed. However, systems were either not in place or robust enough to demonstrate effective management to ensure quality and manage risk. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. The registered manager was relatively new in post and has implemented new systems to mitigate these risks. They told us they have made improvements to medicines, people's weight monitoring and call bell audits and they have implemented new risk

assessments and spot checks. Safeguarding notifications were submitted to us retrospectively. A new COVID-19 risk assessment was introduced for managing staff during an outbreak. We will assess the effectiveness of these at our next inspection.

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

- We received mixed feedback from staff around the management culture. One staff member said, "You can go to them [management team] with issues but if it's staff issues then it just gets ignored. If it is a concern about a resident, they will go and check but then go straight back to the office." Whereas, another staff member told us, "I can raise any concern with the management, they will listen to me."
- Relatives felt the home promoted a positive culture, one relative said, "When we went to visit to see if the home was suitable, we could see how the registered manager talked to the residents and how they all liked them." Another relative said, "It is a happy friendly place. My [family member] is content. I would want to end my days there. We deliberately visit at different times to see what it is like then."
- There were regular team and senior meetings where the registered manager encouraged reflection and provided learning opportunities. A date had been planned for the next senior meeting and many of the issues raised in this inspection had been added to the agenda. This showed how the provider was open to improving the service.

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 registered manager was clear about their responsibilities under the duty of candour. They told us about the importance of running a transparent service and making apologies when things went wrong.
- The service apologised to people, and those important to them, when things went wrong. Letters were sent out to people who had raised complaints apologising to them and seeking resolution.

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

- Monthly newsletters were sent out to relatives containing relevant information about the home and photographs of events which had occurred. There were also regular relative meetings. We reviewed minutes of these meetings. These showed people and their relatives were involved in the service.
- Some staff did not always feel listened to. We received mixed feedback from staff. Some staff told us they did not feel listened to or involved in the service. Others said they were listened to and they could suggest improvements to the service. One staff member told us about a moving and handling suggestion they made which had been taken forward.

Working in partnership with others

- Records reviewed confirmed collaboration with health and social care professionals and showed the registered manager welcomed their views and advice.
- The provider worked in partnership with other social care organisations. The provider was a member of an organisation which connected social care organisations together within the county. They told us how this connection provided information, health and social care updates and training opportunities to staff.

Continuous learning and improving care

- The provider invested in the development of staff and embraced change. One of the management team was completing a leadership qualification. Part of this course consisted of networking with registered managers from other care homes. They told us this had been a great opportunity to share good practice and learn from others.

- The provider had recently signed up to a new oral health initiative. They were in the process of nominating two staff members to attend the programme and then the two staff would be supported to share their knowledge with the rest of the staff team.
- The provider had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.
- The registered manager was relatively new post. They told us how they welcomed the feedback from the inspection in order to learn and improve the care provided.

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 | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12(1, 2adgh). Medicines were not always safely stored or managed. The provider did not always follow their IPC policy in relation to hand safety and LFT results were not sought. Hazardous items were not always secured. Risk to people were not always assessed and people weights were not regularly managed in line with their identified care and support plan.</p> |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17(1) & 17(2ab) Systems to monitor the quality and safety of the service provided were not always effective in identifying shortfalls or driving improvements. Staffing levels during COVID-19 outbreak were not assessed. Safeguarding notifications were not always submitted to Care Quality Commission.</p> |