Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Eden Lodge Residential Care Home is a care home providing personal care to 32 people, some of whom were living with dementia at the time of the inspection. The service can support up to 60 people in one adapted building across one floor.

People's experience of using this service and what we found
People were not always being protected adequately against risk of harm. Risk management was poor, with risks not always being assessed or reviewed. Incidents were not always being recorded or reported appropriately. Medicines management was found to be lacking. There were some poor infection control practices. Recruitment practices were not robust.

People spoke positively about the registered manager of the service. However, we found leadership and oversight to be lacking. There was insufficient risk management and quality monitoring. Statutory notifications were not always submitted when required. The registered manager lacked an understanding around their regulatory requirements.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's needs were not always assessed adequately. Although people spoke positively about the staff that supported them, it was found staff were not supported adequately.

People spoke positively about the food in the service, however management of risks around their eating and drinking was lacking. People were supported to access healthcare services but record keeping around this was inconsistent.

Staff sometimes used undignified language about people who lived in the service. People's information was not always kept private. People said staff were caring and kind however we observed staff not always being respectful and people did not always have a say in how they were being cared for.

People's care was not always planned in a personalised way. People were not always involved in their care planning. Staff were not always provided with enough information to care for people's specific needs. People said they were sometimes bored, and we observed very few meaningful activities.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009.

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 21 July 2017).

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

Enforcement
We have identified breaches in relation to keeping people safe, care delivery, leadership and oversight of the service at this inspection.

Please see the action we have told the provider to take so far at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 also request an action plan for the provider to understand what they will do to improve the standards of quality and safety.

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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Eden Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of 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
Eden Lodge Residential Care Home 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.

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. 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 seven people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, administration manager, senior care workers, care workers and the cook.

We reviewed a range of records. This included twenty people's care records and six medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We reviewed requested information that the provider had sent us. This included training records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People's risks were not always being assessed, monitored or managed safely. Some people did not have any risk assessments in place.
- People who had their risks assessed did not have these reviewed regularly. Risk assessments which had been completed did not provide staff with enough information to safely assist people with their risks.
- Where plans had been put into place to mitigate risks, these were not always being followed by staff. For example, people were not always being repositioned to maintain their skin health according to their plans. This left people still at risk of harm.
- Staff we spoke with said they were not always informed accurately about people's needs.
- Where we saw people identified as potentially choking on their food there was no information to support staff on how to assist these people with their meals or how the food should be prepared.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were not always protected from the risk of infection.
- On the days of inspection, some areas of the service were found to be unclean and good food hygiene practices were not being followed.
- Bathrooms were dirty and being used by staff to support people with their personal care needs.
- Perishable food items, such as raw meat, did not have any dates on as to when they were opened or when they needed to be used by. This did not follow best practice and put people at risk of food poisoning.
- Staff did not always wear personal protective equipment (PPE), such as aprons and gloves when appropriate. Staff we spoke with said there was a lack of PPE around the home and they felt that the home was not clean enough.
- The service had a recent external infection control audit that had identified several actions that had to be taken in order to meet good practice in infection control. It was found that a number of these actions had not been done by the registered manager, leaving people at an increased risk of infection.

This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Systems to manage medicines were not safe.

● Protocols were not always in place for when people were prescribed medicines to be given as and when required. This meant staff may not know when to offer these medicines to people, leaving people at risk of not receiving medicine when they required it or being supported to take unrequired medicines. Staff were not always recording when this type of medicine had been administered.

● Protocols in place for medicines used to reduce someone's anxiety or agitation, did not contain enough guidance for staff as to when to administer the medicines and what alternative could be tried prior to offering this medicine. Staff were not recording if the medicine, when given, had been effective and so were unable to review outcomes.

● There was no system in place to record medicine errors. Medicine administration records were found to inaccurately reflect the amount of medicines in stock, and there were some medicines missing from stock. These issues had not been identified, recorded or looked into.

● A person was supported to receive medicine via a skin patch. However, there was no documentation in place to record the location of where the patch was being placed and guidance was not being followed around how often to alternate the locations. This left the person at risk of skin irritation and inflammation.

● Staff had recently received medicine training, however the registered manager was unable to ascertain who had had their competency to administer medicine checked. This meant the provider could not be assured staff were competent to administer medicines.

This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always being safeguarded from the risk of abuse.

● Although people said they felt safe in the home, the provider did not have a clear system or process in place to safeguard people from abuse or harm. Staff did not always recognise potential safeguarding concerns, as a result these were not always escalated.

● The provider and registered manager failed to report a number of incidents and potential safeguarding concerns to the appropriate agencies. We spoke to the registered manager about this and they had not recognised these as safeguarding concerns. Incidents included people having altercations with other people in the home, people sleeping in other people's rooms and pressure sores.

● The registered manager did not have oversight of these concerns which meant people could be at risk of harm or abuse.

Staffing and recruitment

● Staff were not being deployed in an effective way and safe recruitment practices were not always followed.

● Due to the layout of the home it often took quite a while for people and staff to find each other. A person said, "I came down to look for someone [staff]…. but it was difficult to find someone." The provider did not have a system in place to deploy staff effectively.

● People felt there were enough staff to support them with their needs; but said they could do with more as it was a 'bit hectic' and 'the staff seem to have a lot on their shoulders'.

● Staff had mixed views on the staffing levels. One said, "We do have enough time to sit with people and get to know them. When we have new admission staffing levels do go up". Others felt staffing was short, which meant the use of agency staff and permanent staff working lots of additional hours. This meant staff were working long hours and could put people at risk due to lack of sleep.

● Recruitment records were incomplete and there was a lack of documentation to evidence safe

recruitment and induction processes were being followed. This meant the provider and registered manager could not assure themselves that prospective staff were suitable to provide a regulated activity.

Learning lessons when things go wrong

● The provider did not have a comprehensive system in place to record and action incidents and accidents. Although some incidents were being recorded it was found that a number had not been. For those that had been recorded it was not clear what action had been taken.

● It was not clear that lessons were always being learnt as the same incidents were reoccurring.

● This meant people were placed at risk because issues with the quality of care were not identified quickly through an auditing process, and there was no opportunity for learning and improvement of care.

● There was a good system in place to record and analyse trends in falls. The registered manager demonstrated that they had increased staffing numbers and falls had reduced.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care and support.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider had failed to establish robust processes to ensure valid consent was always obtained and the principles of the MCA were not consistently adhered to. This meant people's legal rights were at risk of not being upheld.
- The provider was not aware of who had a DoLS authorisation and was not always completing mental capacity assessments in relation to restrictive care practices. The provider could not assure themselves that people were being supported in ways which were less restrictive and lawful.
- Mental capacity assessments which were in place had not been reviewed regularly. Where best interest decisions had been made input from relevant parties had not always been documented.
- People's consent was not always being sought. People's bedroom doors were being locked, which was an unjustified restriction and limited their independence against their wishes. One person said, "I like it to be open, but today it is locked. I used to have a lie down in the day, but they lock us out, so we can't have a nap in the day".
- People's consent had not been sought to be recorded on CCTV. Not everyone had been informed there was CCTV in operation throughout communal areas of the home and therefore may not be aware they and their visitors were being recorded.
- Legal conditions for people deprived of their liberty were not being monitored or reviewed.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, and choices were not always assessed sufficiently, and care was not always delivered in line with best practice.
● The provider completed care plans without always taking into consideration people's needs. For example, staff would complete a respiratory care plan for everybody even if they did not have any identified respiratory needs. This meant people's care was not planned with them to meet their individual needs.
● Care assessments for people did not always consider the full range of people's diverse needs. For example, people who had been there for a number of months still did not have plans in place and their needs had not been fully assessed. This lack of assessment could mean that people's diverse needs were not being met.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience
● Staff did not always have adequate levels of support in place to ensure they were able to complete their roles effectively. Staff said, "I've voiced concerns before and [manager] said it was going to change but hasn't happened." Another said, "We have no observations. Some seniors do nothing to help the team. We cope on our own, we can't go to the manager".
● Staff we spoke with said they completed an induction. However, staff records were inconsistent, so the provider could not assure themselves all staff had received a full induction.
● Although people spoke positively about staff's skills, training records indicated that not all staff had completed training in areas such as safeguarding and the MCA. This provider could not assure themselves all staff had the knowledge and skills to support people.
● The provider did not carry out regular staff supervision or competency checks. Staff stated they had no observations and the registered manager was unsure as to when they last had done this. This meant the provider had failed to ensure all staff had received appropriate support, training, and supervision as is necessary to enable them to carry out the duties they are employed to perform.

This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were being supported to eat and drink, but risks associated with people's eating and drinking were not always being monitored and recorded consistently.
● Where people's weight needed to be monitored and recorded, this was not always being done regularly. This left people at the risk of not maintaining a healthy weight.
● People spoke positively about the food. One person said, "I love it. We have a fantastic cook. There's enough to eat. We can say if we would like to have some more."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were being supported to access some healthcare services. However, record keeping around this was inconsistent, which made it unclear if staff knew of changes in people's conditions or if people were being supported to achieve the best outcomes.
● Healthcare professionals spoke positively about staff and the support they gave to people. One described how the service had supported one person to be more independent with their medicines, however we had concerns over how this was being managed. We saw records of the person's blood sugar levels, but staff

were not provided with any guidance as to the person's ideal range or what action to take if they were not in this range.
● Staff did not have quick access to a summary of people's needs; therefore, they could not provide this to other services in an emergency. This meant that essential information to ensure people's needs continued to be met may not have been passed on.

Adapting service, design, decoration to meet people's needs
● People were able to personalise their own rooms as they wished.
● Throughout the home there were signs to help people orientate themselves and there was consistency in decoration to help people identify bathrooms.
● People had a choice of communal areas and quiet spaces to spend their time in. People did have access to outside space, although this was discouraged in winter due to the cold.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always supported to live with privacy, dignity and independence.
- Some people were not supported to dress in a way which protected their dignity. This resulted in people being exposed to others due to a lack of attention by staff. This could make people feel uncared for and affect their wellbeing.
- Staff referred to people using undignified language such as 'feeders' and 'singles'. This could make people feel disrespected and dehumanised.
- People's private information was not always kept securely and risked breaching confidentiality. This was disrespectful to people.
- Some people felt their independence could be promoted better. For example, by having a key to their bedroom.

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People said staff respected their privacy by knocking on doors before entering. People told us they had maintained their independence with tasks such as bathing.
- Relatives told us visiting times were flexible, families could spend time together in private.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always well treated or supported in a caring way.
- Staff did not always interact with people in a respectful way. For example, at times staff ignored people who clearly required assistance in corridors. This could lead to people feeling unsupported and have an affect on their wellbeing.
- However, some people we spoke with said staff looked after them in a kind and caring way. One person receiving care told us, "Staff treat me fine. They are respectful and polite". Another person said, "They ask me how I am and if I want a coffee".

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to make decisions about their care.
- Some people told us mealtimes and access to their rooms was planned by staff. We witnessed people unable to enter their bedrooms when they wanted to, due to staff not being available to assist them and

unlock their bedroom doors for them. This meant people were not always involved in decisions about their care.

● We observed staff talking with people when necessary in order to complete a task, but we did not see staff take time to have meaningful conversations with people.

● Staff did not always offer different options to people, so they could decide for themselves. For example, people were not offered a choice on what drink they wanted to take their medicines with.

● Some care plans were detailed and informed staff if the person could make their own decisions. However, some care plans lacked details about people's own views. This put people at risk of their choices and preferences being overlooked when care was being provided.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

● Care was not always planned in a personalised way that met people's individual needs and preferences. We saw care delivered which appeared to be task-led rather than person centred.

● People who were on respite for a short stay had care plans which had minimal information. There was very limited guidance for staff on how to meet their specific needs. Although when speaking with some staff, they demonstrated they had gained a knowledge of people's needs and preferences through getting to know them, but this was not recorded. This means staff may not be able to support people in a personalised way.

● People who had care plan did not have regular reviews to ensure they reflected the person's current needs, choices and preferences.

● Although some people and their relatives said they were involved in their care planning, this was not a consistent process.

The provider did not ensure that people's care was planned in a personalised way. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008 (Regulated Activities) 2014.

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

● The provider did not ensure that people were engaged in meaningful activities and were not supported to meet their social needs.

●People were not observed to be engaged with any activities on the first day of inspection and minimal on the second day. This could have a negative impact on people's wellbeing.

● People's activity logs indicated that people were not being supported to take part in activities every day. There was an activities coordinator, but they were only employed part time.

● People said, although some entertainment was put on, they do sometimes get bored. A person said, "It's like being in a prison. I am bored out of my mind." Another person said, "A man gets a newspaper and there is a queue of people waiting for it afterwards."

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008 (Regulated Activities) 2014.

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 were not always clearly identified and assessed.

● There was limited information in people's plans on their communication needs or guidance for staff on how to support them.

● The service had available a communications folder that contained picture flash cards and information on communicating with someone with hearing and blindness. However, these were not being used at the time of the inspection.

Improving care quality in response to complaints or concerns

● The provider had an adequate policy and process for addressing complaints, but not for concerns.

● People's complaints were logged and responded to. There was a system in place to review and learn from these monthly.

● Most people said they had no complaints and explained that if they did they would talk to staff in the office.

● However, it was not clear that all concerns were being addressed. For example, one person said they had spoken to staff about missing personal items and they felt they had not got a response. This meant that people may not always feel listened to or responded to, and as a result care quality would not be improved.

End of life care and support

● The service was supporting people who were at the end of their life. They ensured the relevant professionals were involved and appropriate care was received.

● People had regular input from their GP and district nurses. Where appropriate anticipatory medicines were in place. These were to ensure people were comfortable and pain-free in their final days.

● Staff had received training in end of life care to give them the knowledge of how to support people appropriately.

● However, some people did not always have their end of life wishes documented in their records and it was not recorded whether they, or their family, had been asked about these. This meant when the time came people may not be supported in the way they preferred.

● There was inconsistent recording regarding who had stated they did not want to be resuscitated (DNAR). For example, a person who had DNAR documentation, also had it recorded in their care plan that staff should commence CPR in an emergency.

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager did not have a good understanding of their requirements of their registration and lacked oversight of the service.
- There was a lack of accountability and unclear responsibilities within the staff team which led to inconsistent and inaccurate record keeping.
- There was a lack of effective systems in place for quality monitoring and risk management, which led to errors and risks going unidentified. This meant people were at risk of not receiving adequate care and support to keep them safe.
- There was no clear schedule for supervisions, observations or competency checks to ensure regularly the quality of care delivered was up to a high standard.
- There was a lack of leadership from the provider and staff did not feel that they were safely supported by the registered manager. For example, a pregnant member of staff was punched by a service user and staff told us the registered manager witnessed this and took no action.
- Staff did not feel team meetings were productive and the service had declined since the current registered manager had been in post. There was a lack of confidence in leadership and staff had taken their concerns to the provider, but said no action was taken.
- Reporting of incidents was inconsistent which led to them reoccurring as no action was taken. This meant that people were not supported to achieve the best outcomes.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not understand their regulatory duties regarding notifications. They did not know that they had to notify the Care Quality Commission of certain events.

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

- The registered manager had a lack of understanding around what constituted safeguarding. This meant several incidents went unreported and people may have been left at risk of harm or neglect.

● There was a lack of understanding around the duty of candour, which meant the service was not always operating in an open and transparent way. Incidents and safeguarding concerns were not always investigated or acted on appropriately and the relevant people were not always informed.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider did not have the systems and processes in place to achieve effective partnership working.
● Healthcare professionals said the service worked well with them however we found evidence indicating information was not always shared, particularly around potential safeguarding incidents.
● There was no clear system in place to share information with other agencies in an emergency or when people moved to another service. The provider could not assure themselves that accurate information about people's needs could be shared due to a lack of consistent record keeping.

Continuous learning and improving care
● The provider did not have the systems and processes in place to be able to effectively improve care on an ongoing basis.
● There was little evidence to indicate learning from incidents was occurring, especially as not all incidents were investigated. This meant opportunities to improve the quality of care were missed.
● Staff were not having regular supervision which meant there was missed opportunities for reflective learning.
● People said although they did feedback through meetings, surveys and informal chats it wasn't clear it was being acted on. A relative said, "Various things get discussed to improve the home but not much happens."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service actively involved and engaged people and the public.
● A relative said, "I've been involved in residents and relatives' meetings. I built a vegetable trough for the home at a level the residents could sit next to and work on. Probably meetings happen every two months or so."
● People's opinions were sought through satisfaction surveys and people found the manager to be very approachable.
● The service had arranged open days and invited the local community. They were also actively encouraging local businesses and schools to get involved with the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of certain incidents and events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's needs and choices were being assessed sufficiently. The provider did not ensure that people's care was planned in a personalised way. The provider did not ensure that people were engaged in meaningful activities and were not supported to meet their social needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people's dignity and privacy was always upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure all staff had received appropriate support, training, and supervision as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure safe care and treatment. The provider failed to have systems in place to monitor and mitigate risks to service users. The provider failed to have proper and safe management of medicines. The provider failed to ensure safe infection control practices.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have an effective system of quality monitoring and audits to inform them of areas of the service that require improvements. The provider failed to carry out thorough and robust audits required to have the assurances that the systems and processes were in place to protect people from avoidable harm. The provider failed to ensure sufficient managerial oversight of all areas of the home.

The enforcement action we took:

We issued a warning notice.