Asa Care Limited

Camowen

Inspection report

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Date of inspection visit:
12 February 2019

Date of publication:
22 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Camowen is a residential care home for people living with a variety of care needs, including people living with dementia. It is registered to provide personal and nursing care for up to 20 older people. At the time of our inspection, 18 people were living at the home.

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

People's experience of using this service:

● Actions in relation to the control and management of infection were insufficient to mitigate the risk of infection.
● One person had sustained a series of falls, but there was no evidence to show a referral had been made to the falls team. This was followed-up at the time of inspection. The associated risk assessment had not been updated as needed.
● Consent to care and treatment had not always been gained in line with the requirements of the Mental Capacity Act 2005. One person was subject to Deprivation of Liberty Safeguards, but the authorisation for this from the local authority had lapsed and there was no evidence to show this had been reapplied for.
● A range of audits had been implemented to monitor and measure the quality of care and the service overall. However, these had not been effective overall in that they had not identified the issues we found at inspection. This is an area in need of improvement.
● People said they felt safe living at the home and spoke positively about the staff who supported them. One person said, "No-one is ever angry or impatient, you cannot fault them". People were protected from the risk of potential abuse or harm and staff had been trained in safeguarding. People's risks were identified and assessed as needed. Staffing levels were sufficient to meet people's needs and new staff were recruited safely. Medicines were managed safely.
● We observed people were comfortable in their surroundings and felt safe and happy. People were relaxed and willing to have a conversation with us. Throughout our inspection, we observed positive interactions between people and staff. People were treated with dignity and respect and involved in all aspects of their care. One person said, "Carers are very good and friendly, they will stop and have a chat". Staff had been trained in a variety of areas and were skilled and experienced in supporting people. They had regular supervisions and annual appraisals.
● People were complimentary about the food on offer and told us they had a choice of what they would like to eat. One person said, "I like to go down to the dining room and I enjoy talking to my friends". People had access to a range of healthcare professionals and services. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
● People received personalised care that was tailored to meet their individual needs, preferences and choices. Care plans were detailed in the information and guidance provided to staff. Staff encouraged people in decisions relating to their care and in care planning. Complaints were logged and managed

appropriately. People could stay at the home until the end of their lives if this was their wish and their needs could be met.
● People and staff were involved in developing the service and their views were listened to and acted upon. Staff felt the managers were approachable and there was an 'open-door' policy. Staff enjoyed working at the home.

Rating at the last inspection: Good. The last inspection report was published on 20 August 2016.
The overall rating has changed to Requires Improvement.

Why we inspected: This was a planned, comprehensive inspection. The inspection took place in line with CQC scheduling guidelines for adult social care services.

Enforcement: Action we have told the provider to take is included at the end of the report.

Follow up: We will review the service in line with our methodology for 'Requires Improvement' services.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Camowen

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was undertaken by an inspector 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. Their area of expertise was in older people and people living with dementia.

Service and service type: Camowen is a care home. People living in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection: This was an unannounced, comprehensive inspection.

What we did: Before the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The provider completed a Provider Information Return. Providers are required to send us key information once annually about their service, what they do well and improvements they plan to make. This information helps support our inspections.

During the inspection:

- We spoke with seven people who lived at the service.
- We spoke with the deputy manager, the cook, the activities co-ordinator, a care co-ordinator and a care assistant. As the registered manager was on leave, the registered manager of one of the provider's other

homes came over on the day of inspection, and we spoke with them. We also spoke with a chiropodist who was attending people.

- We reviewed a range of records. These included two care records and medicines records. We also looked at two staff files and records relating to the management of the home.
- We spent time observing the care and support people received and interactions between people and staff.

After the inspection, we received an email from the registered manager in response to feedback we provided at the end of our inspection. We have included this in our report.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Preventing and controlling infection; assessing risk, safety monitoring and management

- Insufficient action had been taken in the prevention and control of infection.
- Some people had recently been unwell, so people were encouraged to stay in their rooms rather than meet in communal areas. One person said, "We are confined to our rooms because there is a tummy bug going round".
- After the inspection, the registered manager informed us that the home had been closed to 'outsiders' on the 11 and 12 February as a precaution. However, we met and spoke with a visiting chiropodist who was providing treatment to people at the home on 12 February. There was a risk the chiropodist could have spread the infection when visiting people in other care homes. Neither the inspection team nor the chiropodist were informed the home was closed to visitors at the time of the inspection.
- Closing the home to visitors is an event that is notifiable to CQC. We have written about this further in the Well Led section of this report.
- Risks to people were not always safely managed.
- One person had sustained 11 falls between October 2018 and February 2019, one of which had resulted in a serious injury. No referral was made to the local authority falls team for advice and guidance on how to manage the person's risk of falls. According to the person's care record, they were assessed as being at low risk of falls in a risk assessment dated 15 October 2018. This was inaccurate information. This risk assessment should have been reviewed and updated following the falls.
- We asked the deputy manager to make a referral to the falls team at the time of our inspection. After the inspection, the registered manager told us that they liaised with healthcare professionals regarding this person's risk of falls and how to manage them. The registered manager added that the person's care plan was reviewed on 31 January 2019. However, the person's risk assessment in relation to falls had not been updated.

People were not adequately protected from the risk of infection. Risks to people were not always safely managed. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite this breach of Regulation, steps were immediately taken, once prompted by inspectors, to prevent the spread of infection at the time of the inspection. People were encouraged to stay in their rooms and their lunchtime meal was served to them there. The home was closed to outside visitors. Staff used personal protective equipment to prevent cross-contamination when caring for people. Alcohol hand wash was available for staff and people to use.
- The home was clean and smelled fresh.

● Soiled laundry was kept separately and washed in dissolvable red bags in a sluice wash.
● Apart from the incident described above, risk assessments for people were detailed and appropriate. People's risks were assessed and information and guidance provided to staff on how to manage people's risks.
● Premises were managed safely. Records confirmed the checking and monitoring of gas, electric and fire safety systems.

Staffing and recruitment

● Recruitment systems were established to ensure that new staff were safe to work in a social care setting. Staff files showed that checks had been made with the Disclosure and Barring Service which considered the person's character to provide care. References were obtained and employment histories verified. However, one staff member who had commenced employment on 5 February 2018 did not have two references on their file. These had been requested. In the meantime, the registered manager told us that this new member of staff would be shadowing new staff until their references came through.
● Staffing levels were satisfactory. There were four care staff on duty in the morning and three in the afternoon. At night, there were two waking staff. Staffing levels were based on people's dependencies and assessments were included within care records. One person said, "I think there are enough staff most days and at night".
● One staff member felt there were sufficient staff and said, "We do have enough staff. I try to make time to spend with people". They added that agency staff were never used and any gaps within shifts were covered by existing staff.

Systems and processes to safeguard people from the risk of abuse

● The home provided a safe environment for people. One person told us, "I feel safe because there are locks and keypads on all the entrances and exits, even the garden gate". Another person said, "I am safe because staff know the risks. I don't go out alone, but my friend collects me and we go to the pub".
● Staff completed training in safeguarding. They knew how to protect people from harm and who to report to, if they had any concerns. A staff member explained they would speak with the person and report anything of concern to the registered manager who would then notify the local authority. Staff also understood how to report anything anonymously in line with the provider's whistleblowing policy.

Using medicines safely

● Medicines were managed safely.
● We observed medicines being administered to people by the deputy manager at lunchtime. This was done safely and the deputy manager completed the Medication Administration Record (MAR) after each person had taken their medicine.
● One person said, "I get my pills on time each day". They added that staff were patient and waited for them to take their medicine; they did not feel rushed.
● Medicines were ordered, stored and disposed of safely. Medicines audits were completed which confirmed this.

Learning lessons when things go wrong

● Lessons were learned when things went wrong.
● Procedures were implemented to investigate any issues of concern. Any actions taken were recorded and

outcomes audited to identify any changes to practice to prevent reoccurrence.

● In the Provider Information Return (PIR), the registered manager stated, 'We seek feedback from service users, relatives, staff and professionals. We analyse feedback and, where a shortfall is identified, we develop an action plan to ensure improvement and to enhance our service delivery. We learn from complaints and comments and we share these with our staff'.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Consent to care and treatment was not always gained lawfully.
- Some relatives had signed documents to show that they consented on behalf of their family members to various interventions. For example, one relative had signed their agreement to their family member having their medicines administered by staff and to be weighed. However, the relative did not have the relevant Power of Attorney to make these decisions on the person's behalf. There was no evidence that a best interests' meeting had been held to make the decision.
- Another relative had signed a letter stating they did not wish their family member to receive antibiotics if they became unwell. This is primarily a clinical decision. According to records, the relative did have Lasting Power of Attorney (LPA) to make finance and care and welfare decisions. However, it was not clear whether there were any conditions relating to healthcare decisions under this LPA. The MCA Code of Practice provides guidance on this issue. On page 122 of the Code of Practice, 7.27 states, 'Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where …. a decision relates to life-sustaining treatment'. The Code of Practice further states, 'An Attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this'. At 7.30, it states, 'An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if, when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority'. Not giving a person antibiotics if they become unwell is potentially life-sustaining treatment.
- Coded keypads were situated next to the front door and to the garden gate which meant that people

could not come and go freely. Staff told us that no-one wanted to go out independently and if they did go out, it was with a staff member, relative or friend.
● People's capacity to make decisions had been assessed where it was perceived they might lack capacity. Capacity assessments had been completed where needed. DoLS had been applied for, for one person and had been authorised by the local authority. However, the authorisation was for a period of six months from June 2018. The authorisation had lapsed in December 2018, but had not been reapplied for. We brought this to the attention of the visiting registered manager and the deputy manager who reassured us they would reapply for the DoLS.

Consent to care and treatment was not always gained lawfully. One person was subject to DoLS, but the authorisation for this had lapsed. This is a breach of Regulation 11 (Need for consent) 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 were assessed before they came to live at the home. The Provider Information Return (PIR) stated, 'During the pre-admission assessment, we identify whether any support or special needs are required and this is recorded in the care plan. People are involved in the assessment process and in the development of their care plan'. One person told us, "When I came here we filled in a form about my likes and dislikes. I have everything I want here; it is my home now".
● People's needs were continually assessed and their care and support was provided in line with best practice.
● Care records showed that people's care was regularly reviewed and plans were updated.

Staff support: induction, training, skills and experience

● Staff had the knowledge, skills and experience to support people effectively.
● People told us the staff were well trained. One person said, "They can cope with anything and work hard. I have a special carer who looks after me when she is on duty".
● Staff completed a range of training that was considered to be essential by the provider in carrying out their roles and responsibilities. Training included safeguarding, mental capacity, challenging behaviour, medicines, moving and handling and fire safety.
● New staff completed an induction programme which included shadowing experienced staff. Staff who had not worked in a care setting before studied for the Care Certificate, a nationally recognised, work-based, vocational qualification.
● One staff member said, "We're having a lot more people coming in with dementia. We can ask the manager if we want more training and we have done dementia training".
● Staff told us they were encouraged to study for additional qualifications in health and social care. The cook told us she had studied for a vocational qualification in hospitality and catering.
● Staff received regular supervisions and an annual appraisal and records confirmed this.

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

● People were encouraged to have a healthy diet and there was a menu choice. One person said, "The meals are good, simple fare, you can have a choice". Another person told us, "I sometimes forget what I ordered the day before, but they will always give you something different".
● Special diets were catered for. The cook had a good understanding of people's likes and dislikes and of any food allergies. She said, "We try and come up with new ideas for people. We've just introduced natural

yogurt with fresh fruit and croissants for breakfast and people seem to like that. One staff member goes around with a survey and asks people if there is anything in particular they want. If people don't like something, they will tell you".
● Where people were underweight or had lost weight, the cook told us she used cream or butter to increase the calorie intake for people at risk. Low carb diets catered for people living with diabetes.

Staff working with other agencies to provide consistent, effective, timely care

● Links had been established with health and social care professionals.
● Professionals and specialist services supported people who lived at the home. For example, the home had liaised with the living well with dementia team and the dementia matron. Staff had completed training from the dementia team to meet the changing needs of people. This resulted in people receiving co-ordinated, effective and person-centred care.

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

● The environment had been adapted to meet the needs of people. There was a lift for ease of access to the first floor. A lounge was furnished and decorated in a style popular in the 1940s, with items of interest from that decade. This was well received by people and encouraged them to reminisce about past times.
● People's rooms were personalised. The majority of rooms had en-suite facilities. Everyone was happy with the accommodation provided. One person said, "I love this room and the view. The floor is laminated and I have a nice toilet". Another person told us, "I knitted those squares and made that blanket which is on my rocking chair".

Supporting people to live healthier lives, access healthcare services and support

● People were supported to live healthy lives and had access to a range of healthcare professionals and services.
● One person said, "I used to have pressure sores before I came here. They sent for the district nurse and I don't have any now". Another person told us, "I don't need a dentist. My teeth were kicked out playing rugby!"
● Care records showed that people attended appointments with professionals such as GPs, dentists and opticians. One care record showed that when the person had a chest infection and difficulties swallowing; they were prescribed antibiotics and a referral was made to a speech and language therapist.

Good

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

● We observed staff were kind and caring with people and responsive to their needs. Staff supported people in a patient, warm and friendly manner. We observed one lady continually asking for her husband. A member of staff kindly distracted her train of thought and invited the lady to the conservatory where a cup of tea was offered.
● Positive relationships had been developed between people and staff. The atmosphere of the home was welcoming and engaging and people enjoyed the company of staff.
● One person said, "I like my carers. They know how I like things and what I want to do; they are kind and considerate. You can ask them anything and they will help if at all possible". Another person told us, "Staff do things which suit me. Sometimes I like to get up later than usual and they will come back when I am ready".
● A visiting health care professional said, "Staff are very caring and compassionate and communicate at the right pace with residents while carrying out tasks. They will chat as they work and show sensitivity by using appropriate physical contact, like holding hands".

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

● People were encouraged to be involved in all aspects of their care. Some people preferred that their relatives made decisions with regard to care planning. One person said, "My son is in contact and he discusses care plans and things like that with the manager". Another person told us, "If I have to decide on anything, I ask my daughter".
● We observed staff communicated well with people to make day-to-day choices and decisions. One staff member explained, "If people are new to the home, we ask people what they can do and if they can, we encourage them to do it. If people need a bit of extra help we give it to them. People can choose what to wear and we try and promote their independence".

Respecting and promoting people's privacy, dignity and independence

● People were treated with dignity and respect. People had the privacy they needed and this was respected by staff.
● One person said, "I am always treated with dignity and respect. When staff wash me all over, they cover me discreetly with a towel and make sure the doors are closed". Another person told us, "I am never made to feel a nuisance. If I have a little accident, they treat me with dignity and respect".
● A staff member explained what they would do if a person refused to receive care. They said, "We will go

away and we might try with another member of staff. Nine times out of ten, another member of staff will help".

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People received personalised care that was responsive to their needs. Care plans provided staff with detailed information about people, their likes, dislikes, preferences and personal histories. A new colour coding system had been implemented so staff could see at a glance, specific facts about people. For example, care records with a red code indicated there was a 'Do Not Attempt Cardio-pulmonary Resuscitation' (DNACPR) in place. A brown code indicated the person had difficulty communicating verbally.
● The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals. For example, in one person's care plan, there was a chart which could be used to communicate with the person. The chart included 'yes' and 'no' and pictures representing activities or how the person might be feeling. This meant that staff could communicate with the person effectively and in a way that suited them.
● Care plans contained information and guidance to staff in relation to people's physical and mental needs, sensory impairments, behaviours and mental health, expressing sexuality and relationships, family and friends and hobbies and interests.
● People's cultural and spiritual needs were recorded and met, for example, whether they chose to attend church or to meet with representatives of the church. According to the Provider Information Return (PIR), the core principles of FREDA had been adopted in relation to human rights. This relates to freedom, respect, equality, dignity and autonomy. These principles were key when assessing people's needs and preferences before they came to live at the home.
● People were supported to stay in touch with relatives and friends. Some people had mobile phones to maintain contact and one person had an iPad.

● A programme of activities was organised by the activities co-ordinator which people could access during the week. The activities co-ordinator told us about the kinds of things people were interested in such as games, puzzles, cooking and gardening. The activities co-ordinator said, "We have invited people from the community in for buffet teas. We might have an organ and a sing-along dance. We do crafts, but some people find it difficult, they just want to chat. We don't force anything on people".
● Outings were not planned and, if people wanted to go out, they were reliant on friends or relatives. The activities co-ordinator explained, "We have talked about outings, but would need a mini bus and extra staff. Relatives usually arrange their own outings". Where people chose to stay in their rooms, the activities co-ordinator offered individual time with people, if they wished. One person said, "I go down to the lounge for all the activities". Another person told us, "I stay in my room and don't mix with anyone, although I walk

along the corridor every day for exercise".

Improving care quality in response to complaints or concerns

● Complaints were logged and managed in line with the provider's policy.
● People told us they had no reason to complain overall. One person said, "If I did need to complain, I would tell my daughter and she would speak to the manager". Another person told us, "I have never had to complain, but if I did I would talk it over with the manager, deputy manager or care staff. If you are worried about anything, you can ring your bell and staff will come quickly".

End of life care and support

● If people's needs could be met and it was their preference, their end of life care could be provided at the home. Staff had completed training in end of life care.
● People's last wishes were recorded in their care plans. One person said, "I have discussed end of life care with my family and they know here that I don't wish to be resuscitated". Another person told us, "My doctor and solicitor know my body is going to medical research".
● At the time of the inspection, no-one was receiving end of life care.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high quality, person-centred care. Some regulations may or may not have been met.

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

- Notifications that the provider or registered manager were required to send to CQC by law had not always been received by CQC. However, after the inspection, the registered manager provided additional information which confirmed some notifications had been sent as required.
- The registered manager said that in future, instead of sending notifications via fax, she would use the CQC provider portal or send them by email.
- After the inspection, we were informed that the home was closed to visitors on 11 and 12 February 2019, as a precaution against the spread of infection. This is an incident which should have been notified to CQC. However, according to our records, this had not been received.

Continuous learning and improving care

- A range of audits had been developed to measure and monitor the service overall. There were audits in relation to accidents and incidents. Closed circuit television (CCTV) was used and reviewed when people sustained falls in communal areas to identify ways to prevent reoccurrence. People and visitors were aware that CCTV was in operation. Other audits related to the kitchen, daily care records, cleaning, first aid box checks and reviews of care plans.
- However, these audits had not identified some of the issues we found at inspection, for example, the management of people's risks and that consent to care was gained lawfully. This is an area in need of improvement.
- The rating achieved at the last inspection was on display at the home.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- There was a clear vision and strategy in place to deliver good quality care and support to people.
- Staff felt supported by the registered manager and the deputy manager and told us there was an 'open-door' policy. One member of staff said, "I do like doing care and I like the staff. It's a nice home, I enjoy the work and we have fun. I have a lot of time and respect for [named registered manager]".

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

characteristics

● People were involved in developing the service. Residents' meetings took place and people's views and suggestions were listened to and acted upon. One person said, "They have residents' meetings. I went to one, but choose not to go anymore".
● People told us they felt there was a good management team at Camowen. One person said, "The new deputy is excellent, very caring and understanding". Another person told us, "The manager does lots of work in her office and is approachable". A third person said, "The owner visits every person for a chat".
● We asked people if they felt there were any areas in need of improvement. One person said, "I am happy with everything as it is. I would rate them 8/10 or 9/10. I understand they are going to laminate more floors and they are less of a trip hazard".
● Surveys took place to obtain people's views about the home. Out of seven surveys received, four people felt the service was excellent and three described it as good. In response to one suggestion that people could do more exercise, a new fortnightly exercise programme had been introduced, which included armchair exercises.
● Relatives and visitors had written in a communication book. One relative was complimentary about the home and care and had written, 'The carers do a great job to look after Dad and create a very caring environment".
● Staff meetings took place. Staff told us that any suggestions were discussed and considered for implementation.

Working in partnership with others

● The provider liaised with a range of professionals to meet people's specific needs.
● In addition, the home worked in partnership with other organisations and staff completed training on offer from the local authority and local consortiums. There were good links between the home and the local authority's contracts and commissioning teams. The registered manager stated they attended local events, including managers' forums, to share information and network with other managers.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person or in accordance with the provisions of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate risks. Infection prevention and control were not always managed safely. Regulation 12 (2)