Assure HealthCare Group (South) Ltd

Willow Brook

Inspection report

104 Highlands Road
Fareham
Hampshire
PO15 6JG

Tel: 01329310825
Website: www.assurehealthcaregroup.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Willow Brook is a residential care home providing accommodation for up to 5 people who require nursing or personal care. The service provides support to people with learning disabilities, mental health, and complex needs. At the start of our inspection there were 3 people using the service. The care home accommodates 5 people on the ground floor of 1 adapted building.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Based on our review of key questions safe, effective and well-led, the provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support: 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.

Right Care: People were at risk of harm because staff did not always have the information they needed to support people safely. Medicines were not always managed safely. People did not receive consistent person-centred care that was empowering, of a high-quality and achieved good outcomes.

Right Culture: Ethos, attitudes and behaviours of leaders and care staff did not fully ensure people using services led confident, inclusive, and empowered lives.

Infection prevention and control was not managed safely. There was a lack of timely action by leaders to ensure safeguarding incidents were responded to.

New starters were not trained in a timely manner. This meant they might not always be aware of current good practice. We have made a recommendation about this.

Premises were untidy and unclean. There was a lack of cleaning schedules in place.

People were not being supported to maintain a varied and healthy diet. We have made a recommendation about this.

Leadership was inconsistent. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements. Where the need for

improvements had been identified, these had not been fully implemented. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service.

The provider did not always submit notifications to CQC which is their legal responsibility to do so when certain significant events occur.

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 4 June 2020).

Why we inspected
The inspection was prompted in part due to concerns CQC received regarding a person using the service who sustained a serious injury. This matter is subject to further investigation by CQC. The information shared with CQC indicated potential concerns around the timeliness of seeking medical intervention. This inspection examined those risks.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only, during the inspection we made the decision to look at the effective key question as well.

For the key questions caring and responsive not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 Willow Brook on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk management including infection control and medicines, safeguarding, the Mental Capacity Act, maintaining suitable premises, governance and failure to notify CQC of significant events at this inspection.

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 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 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 always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Willow Brook

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 4 inspectors. Three inspectors were on site and 1 inspector made phone calls to staff.

Service and service type
Willow Brook is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Willow Brook 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager had recently been appointed. They are in the process of applying to become the registered manager.

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. The provider was not

asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We observed interactions between staff and people in communal areas of the service to help us understand the experience of people who could not talk with us. We reviewed a range of records including 3 people's care records and 3 people's medicines records. We looked at 4 staff files in relation to recruitment. We spoke with 8 members of staff including the care director, the manager, the deputy manager and 5 care workers. We received email feedback from 3 professionals and 2 relatives.

Inadequate

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health and wellbeing had not always been assessed and mitigated. This meant the provider could not be assured they were doing all that was reasonably practicable to protect people from the risk of avoidable harm.
- Risk assessments and associated guidance for staff were not always in place. For example, one person's records identified they had a medical condition which affected their heart, there was no risk assessment in place to guide staff as to what to look out for or when to seek medical intervention. The same person experienced depression, there was no risk assessment to guide staff how to support them with this condition. This meant staff may not always know the signs to look out for and may delay the person receiving medical intervention in the event their health deteriorated.
- Risk assessments detailed 2 people were at risk of choking and required staff support while eating. We observed people were not supported in line with these risk assessments which placed them at risk of choking. Only 1 of the 2 people were at risk of choking. This was because 1 of the people who had a choking risk assessment in place was not at risk of choking. This had been copied and pasted from someone else's file in error on 31 March 2022 and had not been picked up by the staff or managers.
- The provider had not ensured all staff had completed the necessary training of staff who were in their probation period prior to supporting people independently with specific needs. For example, we found one occasion where a staff member who had not received training in choking and dysphagia, was supporting a person to eat the incorrect food texture when they required a modified diet. This put the person at risk of choking.
- People were at risk of harm if a fire were to occur as the fire risk assessment had not been reviewed since 2021. The provider had not re-examined the fire prevention and protection measures, they had in place to ensure they still worked effectively.
- The provider failed to ensure fire alarm tests were conducted weekly in line with their policy. The last recorded fire test took place on 8 October 2023. Prior to this date the tests had not been conducted consistently to ensure the fire alarm remained in working order.
- The provider could not be assured staff would respond effectively in the event of a fire. The manager had identified shortfalls during a recent fire evacuation drill and documented that staff required additional training. However, at the time of this inspection, staff had not received additional training to support safe emergency evacuation, placing people at increased risk of harm in the event of a fire.
- There was a risk people and staff would not know who the fire wardens were and who should support them in the event of a fire. Although the manager had completed fire warden training, they had not completed fire safety training. We could not be assured they had the skills and knowledge necessary to be conducting fire evacuations and the provider's Fire Safety Care Homes Policy did not specify who the fire safety lead was, who the fire wardens were or who the services fire advisor was. The policy was undated and

had no review dates. Fire wardens were not always highlighted on the rotas we reviewed to ensure a competent staff member would always be on shift to support in the event of a fire.
● The provider could not be assured lessons were learned when things went wrong. Risk assessments and care plans were not reviewed following incidents and accidents to prevent reoccurrence.

The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored, and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to concerns we raised about fire safety in the service, the manager confirmed they would commence work on rectifying these issues. We reported our concerns about fire safety to the local fire service and the provider told us following the inspection that they were liaising with the fire service. The Fire Service have told the provider about the improvements they need to make.

Systems and processes to safeguard people from the risk of abuse
● The provider failed to implement systems and processes to help protect people from the risk of abuse.
● The provider told us they had raised 34 safeguarding incidents between September 2022 and September 2023 to the relevant authorities. However, we found 2 incidents the provider had not reported to the local authority's safeguarding team and 2 incidents they had not considered as possible safeguarding concerns. For example, a person who had a DoLS authorisation in place left premises twice on their own which put them at risk of harm due to their vulnerability. A DoLS is authorised when a person who lacks capacity requires constant supervision. Additionally, the provider failed to review and update care plans and risk assessments to reduce the risk of a recurrence.
● A professional told us of another 2 safeguarding concerns which had also not been referred to relevant agencies. When people experienced unexplained bruising, the manager had not considered whether these injuries might indicate abuse and if a safeguarding referral was required. This meant signs of potential abuse might be overlooked placing people at risk of harm.
● Records showed all 3 people were checked every 30 minutes throughout the night and 2 people were checked every 15 minutes throughout the day. We asked the manager, the deputy manager, and the care director why they were checked this frequently and they were unable to provide us with an adequate rationale for doing so. There was no documented evidence to show how it had been decided this level of supervision was in the service user's best interests to keep them safe. This meant the provider had not considered whether less restrictive arrangements might be appropriate to keep people safe.
● The provider failed to implement a healthcare professional's guidance to protect a person's skin from breaking down. This person suffered from urine burns and were regularly reluctant to receive personal care. A healthcare professional had advised the provider that it was, "not reasonable to go much longer than 48 hours without staff intervention due to health risks." A risk assessment advised staff to support the person with as required medicines at 72 hours of declining support which went against the advice of the professional and placed the person at risk of neglect.

● The provider failed to review their safeguarding policies and procedures to ensure information was up-to-date and relevant. For example, the provider's safeguarding policy had not been reviewed since February 2020 to ensure staff had up to date procedures. The provider's safeguarding policy stated it was developed February 2020 with a planned review date of February 2022.

The provider's failure to safeguard people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager did inform us the care director was in the process of reviewing policies and procedures.
● In relation to the safeguarding concerns we identified, and reported to us, we shared this information with the local authority safeguarding team.

Preventing and controlling infection
● The provider failed to manage infection prevention and control in line with their policy. This placed people at increased risk of infection.
● Staff did not have access to up-to-date policies and procedures to inform their infection control practice.
● Refuse was not always managed safely. For example, we observed 4 bins without bin liners and lids. Two of these bins had been used to discard used personal protective equipment (PPE). We spoke with the manager about this on the first day of our inspection. However, no action was taken, and we found the same concerns on the second day of our inspection. Other bins without bin liners had no PPE in them but were visibly dirty. This put staff and people at risk of cross contamination.
● People's food was not managed safely placing them at risk of exposure to harmful bacteria and ill health. For example, the provider failed to ensure people's food was in date and stored safely once opened. We observed a packet of dips had been stored in between 2 packets containing raw meats. We found 2 food items which were out of date and 6 food items which had not been disposed of in line with storage instructions.
● No action was taken in response to our feedback about food safety. During our second visit to the service, 3 days later, initial food safety risks we identified were still present. This placed people at continued risk of harm from out of date or unsafe food items.

The failure to assess the risk of and prevent and control the risk of the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Visiting was managed in line with current guidance. The manager told us relatives and friends could visit the service whenever they wanted to. A relative told us, "I know I'd be welcomed. I can just turn up at the home."

Using medicines safely
● The provider failed to ensure medicines were always managed safely.
● People were prescribed flammable emollients for skin conditions. The risk assessments in place did not contain sufficient detail to ensure the risks were managed safely.
● Protocols for 'as required' medicines did not always contain sufficient information to guide staff on how to administer these medicines in a safe manner. For example, people were prescribed medicated creams, PRN protocols did not guide staff where to apply these creams, how much cream to use or for how long to use it.
● One person was prescribed medicines for agitation when required (PRN). We did not find any evidence that there was a protocol in place to guide staff how to use this safely. The manager put a PRN protocol in place for this person on 3 November 2023, however; there was no detail in the PRN protocol to state the minimum interval between doses. Records showed that a staff member had on one occasion administered too much of this medicine in error. The provider's checks had not identified this error to enable the person's wellbeing to be checked with a health care professional, or to establish learning.
● One person was prescribed a medicine that could cause them to become seriously unwell if they were not monitored. There were no monitoring charts in place, no detail of the signs to look out for, or action staff should take if the person's condition deteriorated.

The failure to ensure the proper and safe administration of medicines was a breach of Regulation 12 of the

Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Recruitment policies and procedures were in place to ensure staff were recruited safely. Appropriate pre-employment checks were completed.
- There were enough staff to meet people's needs and rotas confirmed there were enough staff to enable people to receive their assessed hours.

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.

At our last inspection we rated this key question good. At this inspection, the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

- The provider was not working in line with the principles of the MCA.
- Care staff lacked knowledge of the MCA. Staff we spoke with could not describe how they would use the principles of the Act to assess whether people could consent to their care and support and understand associated risks.
- The provider failed to consider the MCA and people's bests interests when implementing restrictive practices. For example, the kitchen was locked preventing people from accessing this area. Care records provided no clear rationale as to why the kitchen was locked at all times, or why people were being prevented from accessing the area to make their own snacks and drinks, instead having to ask staff to open the kitchen. This practice meant people's freedom, choices and rights were being restricted without following any recognised process.
- Where one capacity assessment had taken place there was no recorded best interest consultation to evidence how decisions had been agreed and to ensure people's rights were upheld.
- DoLS applications had been made for all 3 people living at the service. Where DoLS authorisations had expired, new applications had been made. The applications did not include information about all restrictions on people's freedom such as locked kitchen doors, continuous observation or covert medicines being administered to people.

Providing care and treatment without the consent of the person or in their best interests following mental

capacity legislation was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The care director told us they would reassess people to check if they required constant monitoring and to consider if any less restrictive options were appropriate.

Adapting service, design, decoration to meet people's needs
● People were living in a home which was not clean or homely.
● Some minor repairs were required, for example there was damp in the wall in a bathroom.
● We noted a strong malodour in 2 people's bedrooms during both of our inspection visits. Records showed a professional had also noted a malodour in 1 person's bedroom when visiting on 25 October 2023.
● All 3 bedrooms were visibly dirty and unkempt. We observed clothes and bags strewn on floors, wardrobes with items scattered on the floor and piled on the shelves. Bedrooms included trip hazards and people were at risk of harm from an unclean environment.
● One person's bathroom had mould on the wall, and their shower drain was broken and visibly dirty.
● The main kitchen was also visibly dirty with unclean cupboards and the floor had visible debris.
● All service users had kitchen in their private accommodation. However, the electrics were turned off where cookers were in place. We observed one unused kitchen which had unsafe materials left by a contractor such as a large piece of wood with a nail, which was accessible to a person living at the service. This placed the person at risk of harm..

The failure to ensure all premises were clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider's training records evidenced not all staff had received adequate training prior to supporting people independently or without staff supervision.. We have reported on this in the safe key question of this report.
● Not all staff had not been receiving 8 weekly supervision and team meetings in line with the provider's policy, however; the new manager had started to complete supervisions for some staff.
● Staff inductions were not always fully completed. For example, 2 staff started working at Willow Brook several months ago and both had only partially completed their induction books, these were in the staff induction folder. We could not see induction books for 2 other new starters. The deputy manager told us; new starters kept their induction books with them, so we were therefore unable to review these. There was a risk staff did not have all of the required information to conduct their roles effectively and had the potential to put people at risk of harm.

We recommend the provider reviews current induction guidance and updates their practice accordingly.

Supporting people to eat and drink enough to maintain a balanced diet.
● Menus did not always demonstrate people were offered a varied and balanced diet. We reviewed 4 weeks of menus. We found some foods were offered on 3 or 4 occasions a week, for example, soup and toast crackers and cheese, and sausage rolls. Dinner options on 2 days included microwave meals of choice. Vegetables were only recorded in 2 dinners and 2 lunches.
● Staff feedback was mixed, 1 staff member told us, "People are not involved in the menu planning meetings at all." Another staff member told us people are offered 2 choices and pictures of meals were used to help with that choice.
● The provider told us the service has a folder with photographs of meals which staff use to help service

users pick out choices.

We recommend the provider reviews current guidance in recording menu planning and healthy eating and updates their practice accordingly.

● People were weighed monthly and there were no big fluctuations in weight noted.
● We observed a positive mealtime experience for people. For example, a staff member offered people condiments and asked a person to point on their plate where they wanted condiments placed.
● Staff offered people a choice of where they sat for their meals.

Assessing people's needs and choices; delivering care in line with standards, guidance, and the law; Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People's needs were assessed before they moved into the home, however, care plans and risk assessments were not regularly reviewed and updated when people's needs changed. This meant staff did not have the up-to-date information required to enable them to provide people with good person-centred effective care. For example, 1 person's care plan detailed they were a smoker, however, the deputy manager told us we should not mention cigarettes at all to this person because it would be likely to cause him to become angry and agitated because they had stopped smoking and was no longer on patches. During the site visit we observed people from a supported living service walking round with unlit cigarettes in their mouth and hands. During this time, the person was noted to be visibly agitated.
● People and their relatives had not been offered the opportunities to participate in care planning. Documents did not show people or relatives involvement and when asked if relatives were involved in peoples reviews comments included, "Not heard from them for a long time, out of touch for a while, I only get asked if they can have an injection," and, "I have been before, I don't know how often, I could be better informed."
● Care plans were not individualised, or person centred, 1 risk assessment contained information copied and pasted from another person's care records.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- The service was not well managed. Systems and processes were not operated effectively to ensure the service was safe and people were receiving high-quality care. This led to multiple breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- The provider failed to implement robust governance processes and systems to ensure the safe running of the service. Without these systems, the provider and management team could not be proactive in identifying issues and concerns in a timely way and acting on these. The provider failed to identify the widespread and systemic shortfalls we found at this inspection through their own monitoring systems, including in relation to staff training, medicine management, risk management, fire safety and MCA.
- Whilst some audits were conducted, these were not completed consistently or effectively and did not drive improvements. For example, in August 2023 an audit identified no cleaning schedule was in place. Although the manager put a cleaning schedule in place some weeks later, they had failed to check it was being completed. Staff had failed to complete the schedule and no action had been taken which meant people continued to live in an unclean environment.
- People's records were not always complete. For example, 1 person's health overview record was not completed, a document called, "Actions to be taken to improve current assessment" was blank. Another person's record or support notes contained gaps where staff had not completed the notes for their shift. In a 1-week period there were no notes for the morning twice, afternoon twice, evening three times and nights once.
- Care plans and risk assessments were not reviewed on a regular basis. For example, 1 person had risk assessment in place named damaging property. There were no details to say who completed this risk assessment. It was reviewed 4 times in 2022, the last review date being 6 October 2022. This shortfall had not been identified by the provider's own monitoring systems.

The failure to operate effective systems to assess, monitor and improve the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke to the care director about our concerns in relation to care quality and safety. The care director told us audits had not been taking place previously, but they had some audits which they were planning to put in place.

- The provider failed to ensure statutory notifications were submitted to CQC in line with regulations. For

example, we identified 2 incidents of people leaving the service on their own when they had a DoLS in place. These incidents had not been notified to CQC. Statutory notifications inform CQC of notifiable incidents and help us to monitor services we regulate.

The providers failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People, their relatives and staff were not always engaged and involved in planning people's care or in the development of the service.

● People were not given regular opportunities to discuss their individual care needs or wider issues in the home.

● The provider did not have any surveys for people, their relatives, and staff to complete to give feedback on the service provided.

The failure to actively encourage feedback about the quality of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The culture of the service did not reflect CQC's Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control, and independence over their lives.

● During our visit we did observe staff treating people in a kind and caring manner. Relatives were complimentary about the care provided by the regular staff.

● Until recently staff meetings had not taken place for some time. The new manager was starting to hold meetings to enable staff to share their views and discuss issues, although these were yet to include an opportunity to reflect on learning from incidents and accidents that had occurred within the service, and this is an area where further improvements could be made.

● Staff told us they felt valued, listened to, and enjoyed working at the service. Staff were complementary about their colleagues and the support they gave them.

● The manager demonstrated commitment to the service and people who lived there however, improvements were needed to ensure they had the knowledge, skills and time to be able to do this.

Working in partnership

● The manager told us about a weekly call with the GP to discuss people's medical needs. We saw documentation these calls took place.

● When asked if they were kept updated about medical appointments a relative told us, "They do ring us about the big things but not so much small things. Last month no one really rang or messaged." Another relative told us they could be kept more up to date about medical appointments.

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's failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to ensure all premises were clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.