

Rapport Housing and Care Rogers House

Inspection report

Drewery Drive
Wigmore
Gillingham
Kent
ME8 0NX

Tel: 01634262266

Website: www.rapporthousingandcare.co.uk

Date of inspection visit:

21 July 2022

22 July 2022

Date of publication:

16 December 2022

Ratings

Overall rating for this service	Inadequate ●
---------------------------------	--------------

Is the service safe?	Inadequate ●
----------------------	--------------

Is the service effective?	Inadequate ●
---------------------------	--------------

Is the service well-led?	Inadequate ●
--------------------------	--------------

Summary of findings

Overall summary

About the service

Rogers House is a residential care home providing accommodation and personal care for up to 43 people. The service provides support to older people, some of who were living with dementia. At the time of our inspection there were 41 people using the service.

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

Although people we spoke with told us they were happy, we found people were not safe living at Rogers House. Risks had not been identified and mitigated by staff and as a result people had been placed at risk. There was a lack of comprehensive guidance in place to inform staff how best to support people with their health needs including wound care, diabetes, supporting them when transferring and the risk of falls. There was no effective system to learn from accidents and incidents and no system in place to reduce the risk of the incident reoccurring. Incidents of potential abuse had been identified by staff, but not reported or investigated sufficiently.

Medicines management was poor and ineffective. Audits had not been completed and therefore issues with medicines administration had not been identified. These included medicines not being counted to ensure people had received their medicines and ensuring the relevant guidance was in place for staff.

There were not sufficient numbers of staff to meet people's needs and keep them safe. We observed people waiting for support to use the toilet, and there was a high volume of unwitnessed falls. Staff had not been recruited using safe recruitment processes, and staff had not received the training, and competency checks to complete their roles.

People's needs had not been consistently assessed when they were living at Rogers house. When people's needs changed, risk assessments and care plans were not reviewed and there was not an effective system in place to share information with staff. For example, when staff were told to check on a person every 30 minutes by healthcare professionals due to the risk of falls, they were not always doing this. People were not always referred to the relevant healthcare professionals for 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. Staff had made decisions for people and had not always included them in the decision-making process. For example, where people ate their breakfast and having access to personal belongings. Dementia friendly equipment did not work, and in the main area people liked to relax in, the television was broken and therefore people could not watch it.

The culture of the service was not empowering to focus on the needs of people. Staff meeting minutes showed staff did not always speak about people in a positive way. We received mixed feedback from

healthcare professionals regarding the implementation of advice and directions for staff.

There was a lack of effective leadership and oversight. Checks and audits were poor and did not identify significant risks highlighted within our inspection. Statutory notifications had not always been submitted.

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 18 August 2017).

Why we inspected

We received concerns in relation to staffing and wound care. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led key questions. 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 Rogers House on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, staff deployment, staff recruitment, abuse, training, mental capacity, person centred care, and effective checks and audits at this inspection.

Following the inspection, we took immediate action to impose conditions on the provider's registration in relation to risk management, staffing and oversight.

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.

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?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate ●

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Rogers House

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was carried out by two inspectors.

Service and service type

Rogers House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rogers House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, registered manager, care coordinator, senior care workers and care workers including agency staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

- Risk management and assessment was poor. People's care records did not provide sufficient information to identify risks and inform staff how to reduce risks to people. For example, one person had been identified at risk of falling. The person had fallen since living at Rogers House, and staff had been advised by the falls team that the person needed checking on every 30 minutes to reduce the risk of falling. This information was not in their care plan, and daily notes confirmed these checks were not occurring. There was a high volume of agency staff, and some shifts there were only agency staff working. This placed people at higher risk of harm.
- One person was identified by staff as being at high risk of constipation. They have no guidance in their care plan to inform staff of the steps to take if the person was unwell. Although staff told us they would contact the GP when they identified the person could be constipated, we found no record of this. Care records showed the person did not open their bowels for up to 10 days during June 2022. Another person had lost a significant amount of weight. There was no evidence they had been referred to the GP or dietician, and care plans and risk assessments had not been reviewed and updated to provide guidance for staff.
- Some people used a wheelchair to transfer them from one part of the service to another. Following a fall from a wheelchair, a healthcare professional advised staff people should not be left unsupervised whilst in wheelchairs. During our inspection we observed people in wheelchairs were unsupervised for long periods of the day. We reviewed care guidance for some people who had slipped from a wheelchair and identified that their falls and mobility care plans had not been updated following the incidents. Other people's care records did state they should not be left unsupported in wheelchairs, however we observed them unsupported on numerous occasions during our inspection.
- One person slipped from a hoist sling whilst being supported to transfer. They did not have a mobility risk assessment in place at the time of the incident or following the incident. This should have identified the most appropriate type of sling to use and provide staff with step by step directions to use it safely. The person had lived at the service for over a month and care guidance was not in place for them for all aspects of their care. We asked the registered manager to implement a mobility risk assessment on the first day of our inspection and share this information with staff to reduce the risks to the person.
- Some people were at risk of skin breakdown or had a wound. Staff told us one person sustained a wound following a fall. There was no guidance or risk assessment in place to inform staff what to do if the wound deteriorated, or who to escalate concerns to. Staff we spoke with told us they would contact the district nurse with any concerns, however due to the high volumes of agency staff we were not assured people's needs would be known.
- Fire risks were not well managed which increased the risks to people in the event of an evacuation. Not all staff had completed practice fire evacuations. The fire grab bag did not have information needed including an up to date list of residents or personal evacuation plans for people. When people smoked there was no

risk assessment in place to inform staff of risks.

Learning lessons when things go wrong

- Incident and accident management and oversight was poor and had not been used as an opportunity for learning and mitigation of future risks. Falls had been documented but incident records did not detail the action taken to mitigate the risk of the fall reoccurring. Information from the incident was not then used to update people's care plans and risk assessments. Staff knowledge about people, and their risks was limited. There was a high volume of agency staff, and some shifts there were only agency staff working. This placed people at higher risk of harm. There was little oversight into any trends to the incidents such as the time of the incident and the number of staff on shift. There was no evidence that the incidents had been reviewed by the registered manager. We found many occasions when similar incidents reoccurred.
- One incident form documented that a person had alerted staff that another person had fallen. The incident record stated that the risks and hazards pertaining to the incident were; 'lack of staff meant that during the handover there were no available staff on the floor.' We asked what action had been taken to address this risk and were told that there was only one night team leader who worked nights, so on other nights all staff needed to be in handover at the same time to receive information. There was no analysis into the number of staff on, if this needed to be increased or consider what action could be taken to ensure there was always a night team leader on duty.

Using medicines safely

- Medicines were not managed safely. There was only one night team leader employed by Rogers House who worked three nights per week. The other nights, there was no member of staff on duty who was trained and able to administer medicines. Some people had allergies that could cause them to go into shock, in this event staff would not be able to administer their medicine. Other people had 'as and when' medicines like paracetamol prescribed for pain relief that may have needed to be administered during the night.
- One staff member told us that staff did not call the on-call managers to administer medicines but would wait until the day staff started work. Senior staff told us they had to come into work early to start medicine rounds to ensure time sensitive medicines were administered on time.
- Staff did not complete checks of medicines to ensure people received their medicines as prescribed. We completed a reconciliation of medicines and found that medicine administration records (MAR) were not the same as the medicine stock. There was a risk that people may not have received their medicines as prescribed.
- Some people needed medicines on a 'as and when' basis, for example pain relief. We found there was no guidance for staff to follow, to check if the medicine was effective, or to inform the maximum dose of the medicine in a 24-hour period.
- The registered manager and provider had not completed any checks or audits to check on the quality of medicines administration. When medicine errors were identified these had not been thoroughly investigated and poor practice was undetected.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they understood safeguarding processes and would raise concerns about people if they identified them. However, when concerns were raised, appropriate action was not always taken.
- A staff member had identified unexplained bruising to a person and completed an incident form to reflect this. The registered manager did not review the incident form, investigate the unexplained bruising or report

the incident to the local authority safeguarding team.

- Another person had a body map in place that detailed on four occasions staff had identified bruising to the person. The body map stated that the senior had been informed of the bruising but there was no incident form or investigation to inform if an investigation had taken place or if the bruising had been reported to the local authority safeguarding team.

The registered person failed to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

- There were not sufficient numbers of staff to meet people's needs and keep them safe. A relative told us, "No, there's not enough staff. You can't ever find anyone to let you out." Staff told us, "For the needs of the residents we need more staff."
- We observed on two occasions people requesting support to go to the toilet and having to wait for long periods of time. One person asked for assistance and was waiting over 30 minutes before staff supported them, another person had used their call bell but was having to bang on their Zimmer frame to draw attention to them needing support.
- Staff told us there was not sufficient numbers of staff. Staffing numbers were calculated by head office, and the needs of people were not considered when staffing numbers were assessed. Staff told us one staff member worked on the second floor, supporting eight people with personal care, whilst making and serving breakfast which was very difficult. Staff told us, "It's not enough staff and they [management] do not listen."
- People were not always supported by staff who knew how to support them safely. The service used a high volume of agency staff, and there were occasions for example nights when there were no permanent staff. As there was not always detailed guidance to inform agency staff about people's needs and risks people were placed at higher risk. One incident report stated that a person had fallen due to there being no staff present. All staff were in the handover, as there was no senior member of staff on shift. When there was a senior member of staff working, they took handover, and then delegated to the other staff members. There was a high volume of staff vacancies throughout the service and people were supported by high volumes of agency staff. On occasions there was no permanent care staff on duty, and often there were more agency staff than permanent staff. The lack of detailed guidance for staff to follow placed people at risk of receiving inappropriate care and treatment.

The registered person failed to provide enough suitably qualified staff. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- We reviewed three staff files for new staff and found that work histories had not been fully explored. Two staff files had gaps in work histories and there were discrepancies between work histories and references obtained.
- Satisfactory information about any physical or mental conditions that may affect staff ability to complete their roles had not always been obtained. When staff needed assessments completed, these had been done however the outcome of the assessment was not documented before the staff member started working.

The registered person failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

- We were somewhat assured that the provider was using PPE effectively and safely. During our inspection

we observed some staff not wearing their face masks correctly.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- Relatives told us they were able to visit their loved ones whenever they wanted, without restrictions.

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 inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Most agency staff had been supported to complete an induction on their first shift. However, all staff we spoke with told us it was challenging to be supported by so many agency staff who did not know people's needs well. One staff told us, "When you have new agency staff come in you have to show them, by the time you have showed them you might as well have done it yourself."
- Checks had not been completed to ensure agency staff working at Rogers House had the relevant training and experience. Not all agencies documented what training staff had completed, and if this was still in date.
- Permanent staff training was not up to date to ensure staff had the skills needed to support people safely. Not all staff had completed any up to date training in key areas such as safeguarding and fire safety. We found, when we asked staff, they did not all have a good understanding of fire safety. A third of staff did not have up to date moving and handling training, and the majority of staff did not have practical moving and handling training.
- Staff competency checks had not been completed. Not all staff administering medicines had their competency assessed to ensure they were safe to administer medicines. Staff had not all received refresher training in medicines administration to ensure they were up to date on best practice.

The registered person failed to provide appropriate support, training and professional development. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

- Although staff told us they understood the principles of the MCA, we found they did not always put this into practice. People had not always been included in decisions about their care and treatment, for example staff told us everyone ate their breakfast in their rooms. Some people told us they would like to eat in the dining room, but it was not an option. Staff we spoke with told us it had just always been that way.
- Some people had mental capacity assessments in place for some aspects of their care. However, some decisions had been made by managers, without consideration or an assessment of people's capacity for example if people had access to their cigarettes. The registered manager did not identify that they had placed restrictions on people.
- Some people had a DoLS in place with conditions. We found that conditions were not always being complied with. For example, one person was supposed to be supported to access the community regularly, and staff to log when this occurred, and if it did not why it did not. We found the logs completed by staff to not be complete.

The registered person failed to put in to practice the requirements of the MCA is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

- Before people moved into the service they were assessed by managers. The assessment gave a basic account of people's needs but was not explicit about, for example the number of staff needed to support the person with a task. Staff told us they were not told about people's needs before they moved in or asked if they had the staffing capacity to meet them.
- When people moved into the service, there was no clear process to ensure they had a full care plan including risk assessments put in place to inform staff on how best to support them. One person had lived in the service for over a month without risk assessments or care plans to inform staff how to support them with known risks.
- People's needs were assessed using recognised tools including skin integrity and nutritional needs, however these were not updated when people's needs changed or used to inform the person's care plan or risk assessments. For example, when people fell and sustained skin tears their care plans and risk assessments were not reviewed and amended to reflect any changes.

The registered person failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

- People told us they had choice about what they ate and that the food was good.
- Care staff told us they were responsible for serving drinks to people, however they were often busy and rushed. One relative told us they wished there were more staff, to spend more time with their loved one encouraging fluids, especially on hot days.
- One person had been visited by the Speech and Language Specialist (SaLT) who had confirmed their food needed to be cut into small bite sized pieces. The communication book stated the person 'coughed/ chokes' on their food, however there was no care plan or guidance in place for staff to follow. As people were often supported by multiple staff including agency staff we could not be assured staff followed this guidance.

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

- Most people spent time in a conservatory during the day. A relative told us that the TV in this room did not work, and they had not seen the TV on. The provider told us the TV could be used to watch DVDs. We

observed people in this room for long periods of time during our inspection without any kind of entertainment and did not see any staff offer to put a DVD on.

- In one lounge within the service there was an interactive dementia friendly screen that could be used to, for example, to play games. Staff told us that this was never used and we did not observe it being used during our inspection.
- People's rooms were personalised and well maintained, and there was some signage to direct people who could become disorientated to different parts of the service.

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

- People were mostly supported to access healthcare professionals, people were visited regularly by district nurses, the GP and the falls team.
- People's care plans were not always clear on what support people were receiving from external healthcare professionals, and we found instructions had not always been followed. For example, monitoring people in wheelchairs, or regular monitoring of a person at significant risk of falls.

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

- There was a lack of effective oversight from the registered manager and nominated individual which placed people at risk. The registered manager completed a number of checks and audits however these had been ineffective at identifying and acting on issues raised during our inspection. Risks were either not identified or had not been effectively mitigated to keep people safe. The high reliance on agency staff who did not always know people well, coupled with the lack of accurate directions for supporting people increased risks to people.
- Oversight and checks had been wholly inadequate within the service. There had only been two audit visits carried out in the last twelve months by a representative of the provider. The provider, registered manager, care coordinator and senior staff had failed to identify the widespread deterioration of the service.
- The oversight of accidents and incidents was poor and ineffective. Similar incidents re-occurred because incidents were not investigated, and improvements were not made. There was no system in place to review the quality of care plans and risk assessments. A senior meeting carried out in March 2022 identified that care plans and risk assessments were lacking information. However, there was nothing put in place to further monitor this and ensure it had improved. Care plans and risk assessments were poor and ineffective.
- There had been no oversight of medicines administration, training or competencies. The registered manager had requested an increase in staff from the provider earlier in 2022 but did not receive a response, and staffing levels continued not to meet people's needs.
- The widespread and significant shortfalls identified during this inspection had not been identified and acted on. This included the lack of identification of risks relating to people's health needs, the lack of staffing, the issues with the recruitment of staff. The poor assessment of new people, and continued assessment of those living at Rogers House, the lack of training and support for staff and the lack of knowledge around the MCA. Although checks identified a poor culture earlier this year, we found a lack of improvement in this area.
- There was a lack of appropriate referral of incidents to the local authority and CQC. External bodies were not made aware of issues which could impact people's safe care and treatment and enable independent investigation. The registered manager and nominated individual failed to meet their regulatory requirements. During inspection we identified incidents of unexplained bruising which should have been reported to the local authority safeguarding team, and the CQC but had not.

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

- Some people we spoke with gave positive feedback about the service. However, staff told us things had deteriorated and that it was not always a good place to work. Staff told us, "It's horrible. This is the worst I've ever known it. You get days where you think you don't want to come in."
- There was a closed culture which was not always person centred. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse. One person had restrictions placed on them, and staff referred to people by their room numbers. Staff meeting minutes detailed that the way staff spoke with people was 'not acceptable' and that staff 'lacked respect for the management team.' It was not clear to see what, if any action had been taken to address this and improve the culture of the service.
- People were not at the centre of the service, and the registered manager and provider had not always put the needs and wants of people first. For example, people not being asked where they would prefer to eat their lunch, televisions not working in communal areas, and staff playing their choice of music instead of consulting with people.

The registered person failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The registered person failed to maintain accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- In 2021 the registered manager sent out a survey for relatives to complete to give feedback about the service. The registered manager sent a letter to relatives detailing what they did with the feedback received.
- There had been one resident and relative meeting this year. People had given feedback, and relatives had asked, for example for appointments to be set up. There was no follow up to the meeting so we could not be assured that these had been addressed.
- Staff told us they had raised issues with management previously but felt there was no point in raising issues as things were not addressed, for example staffing numbers.
- We received mixed feedback from healthcare professionals. Some professionals told us staff had been responsive and carried out their directions, whilst others told us staff failed to follow their directions leading to health deterioration.

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the registered manager had been open and honest, and understood their responsibility to comply with the duty of candour.
- When incidents occurred, incident documentation reminded staff to apologise to people and their loved ones.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to put in to practice the requirements of the Mental Capacity Act 2005.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from abuse and improper treatment.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively.
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to provide enough suitably qualified staff. The registered person failed to provide appropriate support, training and professional development.

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 assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person failed to manage medicines safely.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care.

The enforcement action we took:

We imposed a condition on the providers registration.