ADA Care Limited

Regency Court

Inspection report

Thwaites House Farm
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Keighley
West Yorkshire
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Tel: 01535606630

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Regency Court is a residential care home providing personal care for up to 22 older people, some of who may be living with dementia. At the time of the inspection there were 18 people using the service. Accommodation is provided in single and double rooms on two floors with stairlift access between floors. Communal areas including a lounge, dining room and conservatory are located on the ground floor.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Government guidance on the prevention and control of infection was not always followed which meant people were put at increased risk. Regular COVID-19 tests were not being carried out on staff or people living in the home. This was put in place after the first day of the inspection.

People did not receive person-centred care and care records did not fully reflect their needs. Medicines were not managed safely. People's nutritional needs were not met.

People were not always treated with respect by staff or had their privacy and dignity maintained. Although some staff were kind, caring and compassionate and treated people well, other staff were task focussed and did not respond appropriately to people's needs. There were few activities taking place and there was little to occupy and interest people.

Staff were not fully checked before starting work in the home. Staff did not receive the induction, training and support they needed for their roles. There were not enough staff on duty to meet people's needs, although staffing levels were increased following the first day of inspection.

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.

There was a lack of consistent and effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People were supported to keep in touch with family and friends through video, phone calls and indoor visits. People had access to healthcare services. Overall people and relatives were satisfied with the service provided.

The manager and provider were responsive to the inspection findings, took action during and after the inspection and shared plans to improve their systems and processes.

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 13 August 2019).

Why we inspected
We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection control, staffing, care provision and risk management. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe and well-led only. We inspected and found other concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing, recruitment, nutrition, personal care, need for consent, dignity and respect and good governance 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Regency Court

Detailed findings

Background to this inspection

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

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
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Regency Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service has not had a manager registered with the Care Quality Commission since April 2019. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started in post in September 2021 and was present at this inspection.

Notice of inspection
This inspection was unannounced. Inspection activity started on 26 October 2021 and ended on 3 November 2021. We visited the service on 26 October and 1 November 2021. We provided feedback to the manager and nominated individual on 3 November 2021. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 commissioners and safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection-
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with the nominated individual and six members of staff including the manager, senior care workers, care workers and the cook.

We reviewed a range of records. This included seven people's care records and five people's medicine records. We looked at three staff recruitment files. A variety of records relating to the management of the service were reviewed

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks to people were not assessed and managed safely.
- Risk assessments were not always in place. This included for the use of sensor mats, for people who were nutritionally at risk or low weight and for COVID-19. Risk assessments were not updated or reviewed when people's needs changed. For example, after a fall or following discharge from hospital.
- Care records did not explain how to keep people safe. Some people were distressed and displayed behaviours that challenged but there was no guidance for staff about how to support the person and manage their behaviour.
- The environment was not always safe or well maintained. An external health and safety report dated June 2021 identified required safety improvements. These had not been addressed.
- The water supply system required attention as there was a loud banging and grating noise when taps were turned on in one area of the building. People reported this was disturbing their sleep.
- Fire safety risks were identified. There were gaps in fire safety checks and improvements identified in a fire risk assessment report completed in 2019 had not been actioned. There were no personal emergency evacuation plans (PEEPs) in place for people living in the home. Not all staff had taken part in a fire drill/evacuation. We reported our concerns to the fire authority.
- There was no current gas safety certificate or legionella risk assessment.
- Accidents and incidents were not always reported, investigated or dealt with appropriately. There were no accident and incident reports for July, August or September 2021, although care records showed accidents and incidents had occurred.
- There was no accident or incident analysis, or evidence of lessons learned.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed actions were being taken to address the fire and health and safety issues.

Preventing and controlling infection

- Government guidance on the prevention and control of infections was not always followed. Staff were not wearing PPE correctly. We saw staff without masks on, staff wearing masks below their noses and under their mouths, one staff member wore a cloth mask. We observed staff were not washing their hands or using hand sanitiser.

● Some parts of the building were not clean. Cleaning schedules were not in place for all areas of the home. Some paper towel and soap dispensers were empty.
● Social distancing was not promoted or implemented by staff. We saw people sitting very close together in the lounge and dining room.
● Government guidance states staff should carry out two lateral flow device (LFD) tests a week and a polymerase chain reaction (PCR) test weekly. People living in the service should be offered a PCR test every 28 days. People and staff were not completing regular COVID-19 tests. This meant risks to vulnerable people were increased because they were at a heightened risk of infection.
● The manager told us visitors completed an LFD test before visiting. However, there were no records of this or of any screening of visitors on arrival. Visits were booked in and PPE was worn. However, visitors met with people in communal areas where other people and staff were present which increased the risk of transmission.
● Government guidance on admissions to the home was not followed. COVID-19 tests and checks were not carried out when a person was unable to self-isolate on admission.
● The provider did not have an infection control policy in place.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed action had been and was being taken to comply with government guidance relation to COVID-19.

Using medicines safely
● Medicines were not managed safely.
● Systems for administering prescribed creams were not clear. Body maps on medicine administration records (MAR) showed where to apply the cream but not when it should be applied. There were gaps on MARs where staff had not signed, so we could not be assured creams had been given. Creams were left out in people's rooms and some were out of date.
● Protocols were not always available for 'as required' medicines. There was no clear guidance for staff about when the medicine could be given, how often, the maximum dose in 24 hours and the time gap between doses.
● People did not always receive their medicines as prescribed. One person received two doses of a medicine in a six hour period; guidance stated there should be an eight hour gap between doses.
● One person was prescribed a pain patch and the manufacturer's instructions showed the patch should be applied to a different skin site each time to prevent over-concentration of the medicine. There were no records to reflect this guidance or show where on the body the patch had been applied.
● Medicine room temperatures were not recorded.
● The manager was unable to provide evidence to confirm all staff, who administered medicines, had completed medicines training and had their competency assessed.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed action had been and was being taken to ensure medicines were managed safely.

Staffing and recruitment

● There were insufficient staff to meet people's needs and keep them safe.

● People told us they felt more staff were needed. One person said, "I think they could do with more staff. When I press my buzzer, I sometimes have to wait a while which can be difficult if I want the toilet."

● There were three care staff on duty during the day and two at night for 18 people. Accommodation was provided over two floors and some people chose to stay in their rooms during the day. Staff told us two people walked around the home at night. We observed periods of up to 15 minutes when there were no staff present in the lounge. On the second day staffing levels had increased with an additional care staff member working during the day and at night.

● The provider did not use a recognised dependency tool to determine the number of staff required. On the second day the manager had implemented a staffing dependency tool.

There were not enough suitably qualified, competent and experienced staff deployed at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes were not robust as required checks had not been completed before staff started work. We reviewed recruitment files for three staff working in the home. None had a current disclosure and barring service (DBS) certificate. Two staff members had no DBS certificate, and a third staff member had a DBS certificate dated 2016. One staff member had no references.

Systems were not in place to ensure staff were recruited safely. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed action was being taken to ensure recruitment checks were completed for all staff.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the home.

● Staff were aware of safeguarding procedures though not all of the staff had received safeguarding training.

● Safeguarding incidents were recorded and showed action had been taken to keep people safe and referrals had been made to the local authority safeguarding team.

Inadequate

Is the service effective?

Our findings

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

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

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

- People's nutritional needs were not met.
- People said the food was nice, although not everyone was offered a choice. We saw the cook asked some people what they would like for lunch and offered them two choices but did not ask others. One person told us, "The food is very good although there is only one choice. If I don't like something, I leave it."
- Mealtimes were disorganised. On both days we spoke with people who, by late morning, had not received a hot drink or any breakfast. At lunchtime staff brought out the meals but did not provide support to people who needed it.
- People's weight and food and fluid intake were not monitored effectively. People who required food and fluid charts did not always have them. Where charts were in place these were incomplete and showed a poor intake. One relative expressed concerns to us about their family member's food intake.
- Care plans showed some people were to be weighed weekly, this was not done. Staff told us the weighing scales were not working.
- There was no effective oversight or analysis of people's weight or food and fluid records to ensure appropriate action was taken.

People's nutritional needs were not always met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed action was being taken to ensure people's nutritional needs were met and new weighing scales had been ordered.

Staff support: induction, training, skills and experience

- Staff had not always received the induction, training and support they required to fulfil their roles.
- We saw no evidence of an induction programme for new staff. One staff member told us they had received half a day shadowing and said training was "on the job."
- Staff said they had completed some online training. The manager provided us with a training matrix which showed only four out of 17 staff listed had completed all the provider's mandatory training. There was no evidence of any specialist training completed by staff.
- Records showed five staff had received supervision in September 2021.

Staff did not receive the training and support they required to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not always acting within the legal framework for MCA. People's capacity to consent to their care and treatment was not always assessed.
● Where people lacked capacity there was no evidence of robust best interest decisions being made with the involvement of people's relatives, advocates and other health care professionals.
● Some people living at the home had sensor mats in their bedrooms to alert staff when they were moving. There were no consent forms or best interest assessments in place for this decision.
● There were no DoLS authorisations in place. DoLS applications had been made for seven people, four of these dated back to 2020. The DoLS tracker showed six of the applications were awaiting allocation and one was awaiting sign off by the Supervisory Body.

People did not have their care and support needs delivered in line with MCA. This was 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; Adapting service, design, decoration to meet people's needs
● People's needs were not always fully assessed before they moved into the home. Pre-admission assessments contained limited information and insufficient detail to advise staff of people's needs and choices upon admission. We saw staff were unsure about one new person's dietary requirements and the pre-admission assessment was not clear. There were no care plans or risk assessments in place for this person.
● The building was adapted to meet people's needs and parts of the environment were homely and comfortable. People had direct access from the conservatory to a safe garden with a covered seating area.
● Some areas of the home required redecoration and refurbishment. The environment did not promote independence for people living with dementia. For example, all bedroom doors were painted white, many had only a number on the door and no name or photo to help people find their rooms. Some clocks were not set to the correct time, some rooms had few, if any, personal effects.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access the healthcare support they needed.
● People's care records confirmed the involvement of other professionals in providing care such as the GP, district nurses, dentist, and optician. There was no record of chiropody visits.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People were not always treated with kindness and compassion by staff.
- People and relatives praised the staff who they described as kind and caring. One person said, "The staff are nice and lovely, very cheerful and I think happy in their work."
- We found people's experiences varied. Some staff were patient, kind and gentle with people. They took time to check people were all right and provided comfort and support when needed, even when they were busy. However, other staff were abrupt with people, did not respond to people's needs and lacked warmth and empathy.
- One person asked staff to take them to the toilet. The staff member started to help the person then broke off to do something else. After 30 minutes of waiting the person managed to get up and go the toilet themselves with assistance from the inspector.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not maintained and staff did not always treat people with respect.
- Some bedrooms were occupied by two people. There were no ensuite facilities and only one commode in the room which staff told us both people used. A curtain was used to screen the person who was using the commode but this did not maintain people's dignity and privacy.
- One person told us, "I think I am a nuisance to [staff]. I can't get about, I wish I could. Sometimes they tell me to wait and tell me I have a pad on so not to worry but it's not nice. I prefer to get onto the commode but can't do it myself."
- Some people looked unkempt. One person wanted a shave, but staff confirmed they did not have the equipment needed to do this safely. Another person had dirty fingernails and greasy hair.
- People were not being offered or receiving regular baths and showers. One bathroom was out of use and a shower room could only be accessed by walking through the lounge.
- A relative said some of their family member's clothes, which were labelled, had gone missing and on occasions they had visited and found the family member in someone else's clothes.

People were not treated by staff with compassion, dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always involved in decisions about their care.

● People and relatives had not been involved in the care planning process. One person said, "They've not sat and discussed my care plan but then I am only here for a short while."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not always receive person-centred care.
- People's care records lacked detail and did not reflect people's current needs. Care files were disorganised and many of the care records were undated and unsigned. Staff said they did not look at people's care records.
- Care plans were not being followed by staff. For example, one person's care plan which had been reviewed in October 2021 stated they required fortified meals, finger foods and prescribed supplement shakes. We observed the person received none of these.
- People's care records were not reviewed or updated when changes occurred. For example, one person had returned from hospital and due to health changes required additional support from staff. This was not reflected in the person's care records.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were not always met.
- Staff did not always explain things clearly or in ways that people could understand. We saw a person who had a hearing impairment was not wearing their hearing aids and could not understand what staff were saying. Staff were raising their voices and speaking in the person's ear, but this did not work and after a while they gave up. The inspector identified the person could read and respond to written information. This form of communication had not been considered by staff.
- No communication aids were used to help people chose food and drink such as pictures of food or showing people different plates of food to help them decide.

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

- People's social care needs were not met.
- There was no planned activity programme and no activity co-ordinator.
- There were limited activities taking place when we visited the home and these were focussed on a small number of people. We saw staff provided nail care to one person, a soft ball was thrown with some others

and two people played a game. Staff spent time outside with one person which they clearly enjoyed.
● Some staff took time to chat with staff. Yet we also observed people sitting for long periods of time without any stimulation or interaction from staff.
● People were supported to keep in touch with family and friends. This included pre-arranged internal visits.

People were not receiving person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed care summaries were being put in place to provide an overview of people's needs and there would be a full review of people's care records.

Improving care quality in response to complaints or concerns
● The provider's complaints procedure was displayed in the entrance to the home.
● The manager was unable to locate any complaint records.
● People and relatives told us if they had any concerns they would raise these with the staff.

End of life care and support
● The manager told us no one was currently receiving end of life care.
● There was no information in people's care records to show discussions had taken place with people and relatives about their wishes and preferences in respect of end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Significant shortfalls were identified at this inspection. There were breaches in relation to safe care and treatment, staffing, recruitment, nutrition, person-centred care and dignity and respect. These issues had not been identified or addressed through the provider's own governance systems.
- On the first day of our inspection we informed the provider of our concerns and requested a response detailing the action they would take to ensure people were safe. The provider sent an action plan which provided assurances. When we returned on the second day staffing levels had been increased and COVID-19 testing and checks had been implemented.
- There was a lack of consistent and effective management and leadership. There had been a number of different managers at the home, but no registered manager since April 2019. A new manager was in post when we inspected. Staff said the manager was fair and approachable and keen to make improvements.
- The manager had identified CQC had not been notified about some incidents. They agreed to make these notifications retrospectively.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. There were no provider visit reports or checks to ensure compliance with regulations.
- There were few quality audits in place and those we reviewed were not effective in identifying issues and securing improvements. Many of the audits were unsigned and undated and where issues had been identified there was nothing to show these had been addressed.
- Systems for managing risks to people's health and safety were ineffective. Accident, incident and falls records were missing which meant we could not be assured these had been dealt with appropriately or that people had received the care and support they required.
- There were no robust systems in place to ensure the premises and equipment were well maintained and safe.
- On both days of the inspection systems were chaotic and records we requested were not available.

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

- Overall people and relatives were satisfied with the service, although concerns were raised about staffing

levels, missing clothes and nutrition. People and relatives said they would recommend the service.
● There were limited opportunities for people to be involved and express their views and opinions about the service. The manager told us there were no records to show any residents meetings had taken place.
● We saw minutes from a staff meeting held in September 2021. The manager could not find any other staff meeting records.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed additional support was being provided for the manager and they were implementing quality assurance systems at both manager and provider level.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals.