Park Homes (UK) Limited

St Stephens Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Stephens Care Home is a care home providing personal and nursing care for up to 40 people across two units, one specialising in providing care to people living with dementia. At the time of the inspection there were 33 people living at the service.

People's experience of using this service and what we found
Risks were not safely managed. Where risks had been assessed and plans put in place to reduce hazards, staff had not always followed them. The registered provider was unable to demonstrate staff had undertaken appropriate training to support people safely with moving and handling. Robust systems were not in place to ensure learning occurred when things went wrong.

Risks relating to fire safety were not well managed. An external fire risk assessment had identified actions were required, but these had not been completed in a timely way. Safety testing and checks on various services/equipment had not been undertaken as required.

Medicines were not always managed safely. Accurate medication records were not consistently maintained. We identified discrepancies in the stocks of people's medicines as well as other issues. We were not assured that the provider was promoting safety regarding the layout of the premises and hygiene practices.

There were not enough suitably experienced staff to safely meet people's care and wellbeing needs. There had been a high turnover of staff and the provider was recruiting new staff. They were heavily reliant on agency staff and had not always deployed staff appropriately. Skill mix and experience had not always been considered. We found staff were often unavailable to support people in the communal area in one of the households and staff found it difficult to respond to all call bells. The registered provider was unable to demonstrate staff had received appropriate induction; training and supervision to carry out their roles effectively.

Staff had not always followed procedures designed to protect people from abuse. However, people spoken with told us they felt safe living at the home. Staff told us they understood the need to protect people from abuse and felt able to report any concerns should they need to.

Records relating to nutritional and fluid intake were inconsistent. We received mixed feedback about the standard of the food provided.

Aspects of people's health and care needs required monitoring and oversight, such as with catheter care, hydration and skin integrity. Daily care records showed people did not always receive consistent or adequate support to meet their needs.

The provider did not have a robust system in place to monitor applications for Deprivation of Liberty

Safeguards (DoLS) authorisations or when any authorisations needed to be reassessed. DoLS authorisations were in place for some people but not all applications had been submitted as required. The nominated individual confirmed these applications were in progress following the inspection. We heard staff seeking consent from people to provide care during the inspection.

Staff had not always ensured people's dignity and privacy was maintained. During the inspection we observed some caring and positive interactions between people and staff. Overall people told us they felt well treated, and staff were kind in their approach. We observed staff being supportive and considerate in their approach to end -of-life care.

People were not always supported in a person-centred way. They were supported to make some choices for example, where they ate their meal or when they went to bed. However, this was inconsistent. People were not provided with opportunities to engage in meaningful activities. There had previously been an activities coordinator at the home, however they were now undertaking a different role and the service was in the process of recruiting a new coordinator.

There were systematic and widespread failings in the way the service was led and managed. The systems and processes for monitoring the quality and safety of the service failed to identify and mitigate risk. There was a lack of auditing and oversight of routine safety checks. Where issues had been identified, the provider had not acted in a timely way to address these.

Prior to the inspection members of the management team had left. Following the inspection, a new manager was recruited. There had been poor communication throughout the staff team and organisation. Staff meetings were not routinely held but this was now being addressed. The provider was working with other agencies such as the local authority to make the necessary improvements.

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

Rating at last inspection
This service was registered with us on 13 October 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the management of the service. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. Following our inspection, the provider had started to work with the local authority and other agencies to begin making the necessary improvements and to mitigate the most serious risks.

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 safe care and treatment, medicines, infection control, staffing, person centred care 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. 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?

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 safe findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our caring findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our safe findings below.

Inadequate

St Stephens Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
St Stephens Care Home 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. St Stephens is a care home with 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 a registered manager was not in post.

Notice of inspection
This inspection was unannounced.

What we did before 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) 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 spoke with eight people who used the service about their experience of the care provided and four relatives. We spent time in the communal areas observing the support people received. We spoke with 17 staff members including, nurses, care assistants, the maintenance person and the cook. We also spoke with quality managers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. These included six people's care records and 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated 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 were not safely managed. Where risks had been assessed and plans put in place to reduce them, staff had not always followed them. For example, where a person required a modified diet to prevent the risk of choking, guidance had not always been followed. Where people ate their meals in bed, staff had not always ensured people were assisted to sit upright, to reduce the risk of choking.
- Where people required positional changes to prevent their skin from breaking down, they had not always received this support in a timely way.
- We noticed some bruising to a person, who told us this may be due to the way staff supported them. The registered provider was unable to demonstrate staff had undertaken appropriate training to support people safely with moving and handling.
- Areas of the building which could pose a risk to people had key padded locks installed, however on several occasions we found such locks were left on the latch and areas accessible to people. We brought this to the attention of a manager on each occasion.
- Risks relating to fire safety were not well managed. An external fire risk assessment had identified actions were required, but these had not been completed in a timely way. Safety testing and checks on various services/equipment had not been undertaken as required. We contacted the fire service to share our concerns.
- Robust systems were not in place to ensure learning occurred when things went wrong. In some cases, we were told accident and incidents forms had been completed but could not be located. There had been no recent analysis of accidents to identify any themes or trends and take further action where needed.

Systems were not sufficiently effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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.

Using medicines safely

- Medicines were not always managed safely. Accurate medication records were not consistently maintained. We identified discrepancies in the stocks of people's medicines.
- We could not be assured prescribed creams had been applied as required.
- Medicines, including controlled drugs, had not been disposed of correctly in line with best practice.
- Powder used to thicken drinks was not always stored safely as required. Fridge temperature checks had not always been carried out appropriately.
- The registered provider was unable to demonstrate staff had received appropriate training to administer medicines safely, as records were unavailable.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the safe management of medicines. This was a further breach of regulation 12 (Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety regarding the layout of the premises and hygiene practices. Areas of the home needed cleaning and tidying.

● Records had not been maintained to demonstrate adequate cleaning was taking place of both the environment and equipment. Absences within the domestic team had impacted on this.

● The provider could not demonstrate all staff received infection control training to ensure they understood their associated roles and responsibilities.

● We were not assured staff were using and disposing of personal protective equipment (PPE) effectively and safely. For example, after supporting a person in their bedroom the staff member did not remove their PPE correctly.

● Testing in relation to COVID-19 for people and staff had been carried out but was not always in line with current government guidance.

● Infection control and prevention (IPC) audits had not been undertaken routinely. We shared our concerns with the local IPC team, who carried out a visit.

We found no evidence that people had been harmed however, the provider had not taken reasonable steps to protect people from the risk of infections. This placed people at risk of harm. This was a further breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was facilitating visits to the home in line with current government guidance.

Staffing and recruitment

● There were not enough suitably experienced staff to safely meet people's care and wellbeing needs. There had been a high turnover of staff, numerous staff including the manager had recently left. The provider was recruiting for new staff.

● There was a significant reliance on agency staff to cover shortages in regular staffing. Some agency staff attended the home regularly however others were unfamiliar with people's needs and staff told us this impacted on the way care was provided.

● Staffing levels had not been calculated based on people's care needs. The registered provider had a dependency tool to help assess staffing levels, however this had not been used for several months. Staff were very busy and at times we observed it was difficult for them to respond to call bells in a timely way.

● During the first morning of the inspection staff were very behind supporting with breakfast and personal care. One person told us it was a "bad day" as their personal care needs had not been met in a timely way. Comments included "Staff are usually obliging but they have a lot to run" and "You might press the bell at the wrong time, sometimes you have to wait."

● Staff were not always deployed appropriately. Skill mix and experience had not always been considered. We found staff were often unavailable to support people in the communal area in one of the households.

● The system in place to confirm agency staff members' identity, training and Disclosure and Barring Service (DBS) status and training was not robust enough, this information was not available for the staff on duty. Otherwise staff had been appropriately recruited to the service.

There were insufficient suitably experienced and competent staff deployed to ensure the safety and wellbeing of the people who lived at the home. This was a breach of regulation 18 (Staffing) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the nominated individual confirmed they had appointed a new manager at the home. The number of care staff on one of the households was also increased by one.

Systems and processes to safeguard people from the risk of abuse

- Staff had not always followed procedures designed to protect people from abuse. We observed some bruising to a person, which staff had noted on a body chart, however there was no further record to demonstrate whether the cause had been considered or if this needed to be escalated through local safeguarding procedures. We asked the nominated individual to refer this to the local authority under safeguarding procedures.
- The registered provider was unable to demonstrate all staff had been suitably trained in safeguarding people.

Systems and processes to prevent abuse had not been effectively followed. This was a breach of regulation 13 (safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People spoken with told us they felt safe living at the home. Staff told us they understood the need to protect people from abuse and felt able to report any concerns should they need to.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The registered provider was unable to demonstrate staff had received appropriate induction, training and supervision to carry out their roles effectively, including adequate induction training for agency staff.
- The registered provider had introduced a new eLearning system; however records were unavailable to demonstrate whether staff had undertaken any of this training. Staff said they had previously undertaken some training but not recently.
- Staff told us, and records indicated they had not received any recent supervision meetings or discussions with their line manager.
- The nominated individual confirmed various staff meetings had not taken place as they would have expected, which impacted on effective communication. However, they had begun to reintroduce a daily staff meeting and would be planning supervision meetings.

We found no evidence that people had been harmed. However, systems were not robust enough to demonstrate staff had received appropriate training and supervision to support people safely. This placed people at risk of harm. This is a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- As noted in the safe section of this report, we were concerned about the management of nutritional risks.
- Records relating to nutritional intake were inconsistent and we were not assured people had received sufficient nutrition and hydration. One person had recently lost some weight, however during the inspection they had not received support in line with their care plan.
- Fluid charts were in place to monitor people's fluid intake; however, these did not include people's target intake, or total how much a person had taken. Effective monitoring was not taking place to identify where any further action was needed.
- People's nutritional needs were considered within their care plans, however care plans were not always up to date. One person's care plan said they needed a modified diet which they were not currently receiving, however a manager confirmed their needs had now changed but the records had not been amended to reflect this.

Systems were not sufficiently effective to assess, monitor and mitigate risks in relation to their nutritional and hydration needs. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback about the food on offer. People told us, "The meals aren't very good, you always get soup at tea-time and the plates aren't hot, although the sponge pudding is good." and "It's mixed, sometimes it's better than others."

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

● Aspects of people's health and care needs required monitoring and oversight, such as catheter care, hydration and skin integrity. Daily care records showed people did not always receive consistent or adequate support to meet their needs.

● Assessments were undertaken when people moved to the service and their care plans developed from these. However, these were not always fully completed in a timely way.

The provider had not ensured people who used the service received 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 home was linked to a local GP surgery. Where required people had been referred to other health professionals for guidance and support, such as dieticians or physiotherapists.

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

● Areas of the building were worn and in need of redecoration.

● There were various pieces of equipment stored in communal spaces and corridors around the building, which could pose hazards and impact on ease of cleaning.

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 did not have a robust system in place to monitor applications for Deprivation of Liberty Safeguards (DoLS) authorisations or when any authorisations needed to be reassessed.

● DoLS authorisations were in place for some people but not all applications had been submitted as required. The nominated individual confirmed these applications were in progress following the inspection.

● In some cases, people had signed their care plans to confirm they consented to their care and treatment. We heard staff seeking consent from people to provide care during the inspection.

● The provider was unable to demonstrate staff had been trained in the principles of the MCA. However, staff spoken with had some understanding of issues around capacity and when to act in people's best

interests.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Staff had not always ensured people's dignity and privacy was maintained. Where people remained in their beds, their doors were often left open and they could be seen from the corridor. On two occasions we asked staff to support people to ensure their dignity was maintained.
- Records including personal and confidential information was not always kept securely.
- People's files including daily records were left on handrails outside people's bedrooms and were accessible to visitors. This has been identified by a senior manager who told us they had raised this with the staff, although this continued to be an issue.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Overall people told us they felt well treated, and staff were kind in their approach. People commented, "The staff are lovely" and "I've never had an unkind word."
- During the inspection we observed some caring and positive interactions between people and staff. One staff member sat holding a person's hand whilst they waited for their lunch.
- The provider had an equality and diversity policy in place which stated training sessions should be established, however the provider was unable to demonstrate all staff had undertaken such training.
- People and their relatives felt there had been less opportunities to be involved in decisions about their care. People told us communication had not been particularly good and more recently had been less effective.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 were not always supported in a person-centred way. They were supported to make some choices for example, where they ate their meal or when they went to bed. However, this was inconsistent. One person told us they got out of bed when the carer arrived and said they didn't think they had a choice about this. Another said they were given porridge for breakfast, but they weren't keen on porridge so told the staff not to bother.
- Staff were extremely busy and focused on getting tasks completed which was not always in line with people's preferences. One person said they usually liked to get up and sit in their room, but it was almost lunchtime on the day of the inspection, and they were still in bed, as staff were running late.
- Care plans were not always fully completed or reflective of people's current care needs. One person had moved to the service several weeks earlier but several of their required care plans had not been fully completed, this was especially important as many of the staff were agency staff and not as familiar with people's needs
- People were not provided with opportunities to engage in meaningful activities. There had previously been an activities coordinator, however they were now undertaking a different role and the service was in the process of recruiting a new coordinator.
- During the inspection we found no activities taking place, staff were busy responding to people's personal care needs and were unable to spend any meaningful time with people to provide other types of support.

We found the provider had not ensured people who used the service received person-centred care. This was a further breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider had a policy in place in relation to providing information in an accessible format.
- People had communication care plans in place. However, aspects of people's communication needs had not always been fully considered.
- Where a person was unable to communicate when they were in pain, further assessment and use of tools

to support the person had not been utilised.

Improving care quality in response to complaints or concerns

● The provider had a policy and procedure for dealing with complaints, however the procedure was not clearly displayed at the home.

● There was a system to record complaints and how these were addressed, however records were not robust and old procedures remained in the file relating to the previous provider.

● Overall people told us they knew how to raise any concerns and felt able to do this. However, a relative said they had raised an issue about a minor environmental issue several months ago which had still not been resolved, although this was now in progress.

End of life care and support

● Care plans considered people's wishes and preferences regarding their end-of-life care.

● Staff spoken with about end of life care expressed the importance of providing effective care and support to people and their relatives. We observed staff being supportive and considerate in their approach in relation to this type of 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.

This is the first inspection for this newly registered service. This key question has been rated 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; 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

- There were systematic and widespread failings in the way the service was led and managed. The service was registered under the current provider in October 2021. The transfer from the previous provider had not been well planned, including the integration of new systems and procedures.
- There remained numerous challenges in relation to the way the registered provider operated the service, including staff not yet being able to access all electronic records and systems.
- There was no registered manager in place. Several of the home's management team had left prior to the inspection, which had caused instability.
- Members of the senior management team were present at the service during the inspection; however they were also dealing with staffing shortages and management issues within the provider's wider organisation which significantly impacted on their time and capacity.
- The systems and processes for monitoring the quality and safety of the service failed to identify and mitigate risk. There was a lack of auditing and oversight of routine safety checks. Where issues had been identified, the provider had not acted in a timely way to address these.
- The provider did not have adequate oversight of staff induction, training or supervision.
- There was a lack of checks carried out on the quality and accuracy of the information in relation to people's needs, risks and the care delivered. People's care records were not always complete, accurate and contemporaneous.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. 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.

- Following the inspection, the nominated individual confirmed a new manager had been appointed and submitted an action plan with some urgent actions to make improvements, along with details of further resources to be implemented.
- The nominated individual was aware of the requirement to notify CQC of certain incidents and we saw notifications had been received where required.

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

outcomes for people

● People did not always receive person centred care with good outcomes. They did not always receive care and support when they needed it and this placed them at risk of possible harm.

● Some staff were longstanding members of the team and were dedicated to providing effective care. however, morale had been affected with ongoing management changes and uncertainty.

● There had been poor communication throughout the staff team and organisation. Staff meetings were not routinely held. The nominated individual was addressing this and had reintroduced clinical risk meetings.

● Some people were positive about the support they received and told us they had no complaints.

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

● The local authority and clinical commissioning group (CCG) were working closely with the provider in response to concerns about the care provision and organisation of the service.

● Relatives said they were generally kept informed about any changes to their relative's care or health needs. However, whilst care plan reviews were recorded there was little evidence people or their relatives had been involved in these reviews.

● People had not been asked for any recent feedback about the management of the service. The nominated individual said the provider sought feedback through quality surveys, but these had not yet been sent out. Some webinars had been held to update people on the changes.

● The provider was working with other agencies to make improvements, such as the local infection prevention and control team.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found the provider had not ensured people who used the service received person-centred care.

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 Systems and processes to prevent abuse had not been effectively followed.