Whitelodge Alveley Limited

Arden Grange Nursing & Residential Care Home

Inspection report

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Date of inspection visit:
20 October 2022
24 October 2022

Date of publication:
28 December 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Arden Grange Nursing and Residential Care Home provides nursing and personal care for up to 45 people including people with dementia. At the time of the inspection there were 31 people using the service.

The home is an adapted building with all care provided on the ground floor. People have access to lounges, dining areas and accessible outdoor spaces. Bathrooms and toilets are situated near to all communal areas.

People's experience of using this service and what we found
People were not always cared for safely. Lessons were not always learnt if things went wrong. People were not fully protected from the risks of infection. People were protected from the risk of abuse

People did not have detailed care plans or risk assessments which meant staff may not have the information to support people safely. People were not always supported in a timely manner at mealtimes meaning their hot food could go cold. Staff did not always meet people's support needs at mealtimes.

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.

People were not always treated with dignity and respect at the home. People could not be assured that their equality and diversity would be respected as the provider had not identified their preferences or characteristics for staff to be aware of

People could not be assured they would receive person centred support as care plans lacked detail about the people they were written for. People's communication needs were not being met.

People could not be assured that the provider's governance and oversight was effective at identifying concerns and making timely improvements.

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 August 2022).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made but further improvements were required, and the provider remained in breach of regulation and new breaches of regulation were found.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 14 and 20 June 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this comprehensive inspection to check they had followed their action plan and to confirm they now met legal requirements, which they had not.

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

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the relevant safe, effective, caring, responsive and well led sections of this full report.

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 Arden Grange Nursing and Residential Care 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 monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, consent to care and treatment, dignity and respect, person centred care and governance of the service 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
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?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led findings below.

Arden Grange Nursing & Residential 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
Three inspectors carried out the first day of the inspection. One inspector returned on the second day to complete the inspection.

Service and service type
Arden Grange Nursing and Residential 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. Arden Grange Nursing and Residential Care Home 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been appointed and had applied to register. We are currently assessing this application.

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 8 members of staff including the manager, nurses, senior care assistant, care assistants and domestic staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included 6 people's care records and medicines administration records. Quality monitoring systems and a variety of records relating to the management of the service, including policies and procedures 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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and infection control. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● At the last inspection we found that risks to people were not fully assessed or managed, at this inspection we found people continued to be at risk of avoidable harm.
● Where people had known medical conditions, the provider had failed to assess risks to people or develop detailed plans of care. For example, one person's care plan contained a document about medical conditions, but the provider had failed to assess the risks of potential harm from these conditions or develop plans of care for staff to follow to avoid this harm. This placed the person at an increased risk of ill health.
● In areas accessible to people including those living with dementia we found unlocked rooms and cupboards that contained products that if misused could be hazardous to people's health. The Control of Substances Hazardous to Health (COSHH) states that such products should be stored securely, such as in a locked room when not in use by staff. For example, we found that the hair dressing salon was unlocked in an area accessible to people living with dementia. In the salon we found a number of products that were harmful to health if ingested.
● People were not fully protected from the risk of falls from height. A small conservatory being used as a staff room was unlocked and accessible to people. Windows in the conservatory did not have window restrictors fitted to prevent people climbing or falling from the window.
● At the last inspection we found safety checks were not being carried out consistently by the provider. Whilst we saw improvements to the frequency of the checks at this inspection, we found that they were either not always effective at identifying concerns or ensuring action was taken when concerns were found.
● The provider was carrying out checks on the hot water outlets in the home and had recorded temperatures in one person's bedroom which was likely to cause scalds. Despite these being recorded for 3 months, the provider had failed to take any action to resolve it. We shared our concerns with the manager and the temperature regulator was adjusted to reduce the temperature whilst we were there. The bedroom was unlocked and had placed people at risk of scalds.
● The provider had commenced safety checks of people's wheelchairs. Records showed that since the checks had commenced no faults had been found, however, we found 3 chairs that were in use despite

having faults with their footplates. This placed people using the chairs at risk of avoidable injury.
● At our last inspection we found the management of the risk of Legionnaires disease were not effective. At this inspection we found that risks were still not being managed. The provider was not following the guidance provided from the health and safety executive. This placed people at an increased risk from Legionnaires disease.
● People had an increased risk of falls in a part of the home. The handrail in one corridor used by people had a missing section and there was nothing for people using the handrail to hold.
● People were not always supported to maintain a healthy diet to avoid weight loss and malnutrition. A person's care plan identified them as being at risk of malnutrition and that they were losing weight. It instructed staff that the person may require full support to eat and drink and they should prompt the person by giving them their first spoonful of food at mealtimes. We saw staff leave a meal in front of this person for 50 minutes with no interventions before removing it untouched. This placed the person at increased risk of further weight loss and malnutrition.
● We found where people were at risk of developing pressure sores, the provider was not always ensuring that special equipment was used correctly to reduce the risk. We found 2 pressure mattresses had an incorrect setting for the people's body weight. This placed those people at an increased risk of skin and tissue damage.
● At our last inspection there were wooden surfaces around the home that were either bare or had damage to coverings that meant effective cleaning could not take place. At this inspection we found that these had not been addressed. This meant people were placed at a higher risk of infections because effective cleaning could not take place.

Systems had not been established 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 continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection we found infection control was compromised by poor cleaning and records of cleaning were incomplete. At this inspection we saw improvements to both the cleanliness in the home and cleaning records.
● 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 using personal protective equipment (PPE) effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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.

Visiting in care homes
● The provider was allowing visiting at the home in line with government guidance.

Systems and processes to safeguard people from the risk from abuse

At our last inspection we found that the provider had failed to assess, monitor and mitigate the risks of inappropriate or unnecessary restraint. This was a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of

Regulation 13 (Safeguarding service users from abuse and improper treatment).

● At our last inspection we found that the provider had failed to assess the risks to people who may require restraint to protect themselves or others, and there were no plans of care for staff to follow that could avoid the use of restraint. At this inspection we found improvements had been made and this had been addressed.
● The provider had systems and processes in place to protect people from the risk of abuse.
● Staff received training in safeguarding people from the risk of abuse. Staff recognised what abuse was and what actions they should take if they witnessed it.

Staffing and recruitment
● Staff were not always recruited safely. During the inspection the manager advised us there were no records of checks made to the Nursing and Midwifery Council to ensure they were fit to work with vulnerable adults and had no restrictions on their practice. They also confirmed that no periodic checks were carried out to ensure that they remained suitable to work with vulnerable adults.
● At the last inspection we found that the provider was not obtaining full employment histories when new staff joined the company. At this inspection we found that this had been addressed. Records showed references and Disclosure and Barring Service (DBS) had been obtained before staff commenced their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The home continued to have high number of vacancies across its staff team. These vacancies were being filled by agency staff. The manager told us about the difficulties they were continued to have in filling the vacancies and were in the process of recruiting staff from overseas.

Learning lessons when things go wrong
● At our last inspection we found breaches of regulations and the provider sent us an action plan to address these concerns. The local authority and the Clinical Commissioning Group had also found a number of concerns relating to the care, support and safety of people using the service.
● We found the provider had not taken enough action to improve the service or learn when things went wrong. For example, concerns had been identified regarding people not having risk assessments or care plans for specific health conditions. However, we found people continued to lack these, placing people at continued risk of harm.

Using medicines safely
● People received their medicines as prescribed and these were administered by trained staff. Protocols had been drawn up considering people's preference as to how and where they would like to have them administered.
● Where people were prescribed PRN (as required) medicines, guidance was in place for staff on when and how to administer these.
● Medicines administration records (MARS) were correctly completed with no gaps.
● Medicines were stored securely and at the right temperature and we evidence temperatures were checked regularly

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not meeting the requirements of the MCA. In one person's care plan we found under each section it stated, "unable to make informed decisions because of their learning disability". This is against the principles of the act and there were no capacity assessments to support these judgements. This meant that this person was not supported to have maximum choice and control of their life.
- We found where people lacked capacity to choose to reside at the home, some authorisations granted under the Deprivation of Liberty Safeguards had been allowed to expire with no action taken to renew them. For example one person's records showed their authorisation had expired for 3 years before it was renewed. This meant some people were being deprived of their liberties unlawfully.
- Some people had DNAR (do not attempt resuscitation) or RESpECT forms in their files. These are forms to indicate an advanced decision that either they or their family or medical professional had decided that in the event of the person requiring resuscitation, it would not be provided. We found 4 of the people's plans of care we checked contained invalid forms as they were written when they resided at different addresses and new consent forms should have been completed after the person moved to the home. This meant people's legal wishes might not be carried out at the end stage of their life.

People were not supported to have maximum choice and control of their lives and the policies and systems in the service did not support this practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

● Staff completed a training programme to give them the knowledge and skills for their role. However, at the last inspection our findings showed numerous shortfalls in staff's knowledge and skills. Whilst the provider could demonstrate staff had received training, they had failed to ensure the training provided staff with the skills and knowledge they needed to give safe and effective care.
● At the last inspection we identified staff had not received training in 'de-escalation' techniques for when people became anxious. This training had still not been provided and the manager told us this had been arranged but had been cancelled twice due to unforeseen circumstances. The manager confirmed that this was being re-arranged.
● We found concerns with the management of the risk of Legionnaires disease at the home at the last inspection and during this inspection. We spoke to the staff member the provider had delegated to carry out the preventative measures for this. They confirmed they had received no training to help understand what they were required to do.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported by staff at mealtimes to ensure their hydration and nutritional needs were met. For example, we observed a person given their lunch. After 45 minutes a carer without asking the person if they wanted it, poured gravy on the meal and walked away. They returned 2 minutes later and removed the meal. At no time did staff offer encouragement to the person to eat their meal. This meant that the person had not eaten any lunch. We have further commented on this in the safe section.
● Where people required modified diets, we saw they were offered.

Adapting service, design, decoration to meet people's needs
● At the last inspection we found signage and information at the care home had not taken account of peoples' different communication needs. At this inspection we saw that the provider had made improvements and there were now signs and information in different formats.
● All of the accommodation and communal facilities were on the ground floor of the property and there were gardens that were accessible.
● We saw people were able to decorate their rooms to their personal taste.

Staff working with other agencies to provide consistent, effective, timely care
● The home was visited by a local GP weekly and we saw evidence of their involvement in people's care plans.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; Ensuring people are well treated and supported; respecting equality and diversity

● People were not always treated with dignity and respect at the home. For example, we saw that one person's care plan stated they should be supported to wear a hearing aid and glasses. We saw the person sat in the lounge without either. We raised this with the manager who advised the person declined to wear the hearing aid, but they should have their glasses on.
● A person's care plan stated staff should lower themselves to eye level to maintain eye contact to help the person understand what was said. We observed staff failing to follow this guidance when communicating with this person which resulted in the person repeatedly asking the staff member to repeat what they were saying.
● Care did not take place in a timely way. For example, one hour after lunchtime had ended, people remained sat in wheelchairs in the dining room. Staff told us they were waiting for a hoist; however, the people did not require a hoist.
● Staff did not show respect toward people. For example, where care and support was delayed in being given to people, staff did not explain this to them or offer any explanation or apology.
● The provider did not ensure staff consistently showed respect toward people. For example, in some care plans reviewed, we found records referred to people by the wrong name, or a name had been crossed out and a different name written in. This compromised people's dignity and respect by failing to refer to them by the right name.
● Staff did not always demonstrate a caring approach toward people. Where we saw drinks and hot food placed in front of a person, staff did not communicate with the person or give them the support they needed.
● The provider did not demonstrate a caring approach. Where shortfalls had previously been identified though our previous inspection and other healthcare professional visits, they had failed to make sufficient improvements. Where the provider's own checks had identified the need to make improvements, these had not always taken place which showed a lack of care and respect toward the people living at the home.

People were not consistently treated with dignity and respect. This was a breach of Regulation 10 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
● During our inspection we were informed 'feedback surveys' had been sent to people, but there were no

replies received and that they would be sending them again. This meant we could not be assured people, or their relatives were always invited to give feedback or that this was acted on.

● At our last inspection we found people had not been supported to express their views or be involved in making decisions about their care. At this inspection we found that people had been given the opportunity to take part in meetings. We saw that the first meeting had discussed what activities they wished at the home and we saw that the provider had adjusted the activities on offer to reflect these choices. Another meeting was planned to discuss the menus.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care

At the last inspection we found people could not be assured that their care would be person centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- People did not always receive person centred care. People's relatives and friends were not always involved in their loved one's care.
- People's plans of care were generic and were not personalised to the individual. People had the same outcomes identified for the care and support regardless of who they were or what the plan of care was about
- We found after the last inspection the provider had taken steps to review people's plans of care and identified where improvements were required. However, we found some people had still not been consulted and their care plans lacked details about their personal histories, likes and dislikes, religious and cultural backgrounds. This meant we could not be assured that people were receiving care that met their needs and reflected their preferences as the provider had not sought them.

People could not be assured that their care would be person centred. This was a breach of regulation 9 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 relation to communication.

- People did not always get their communication needs met. We observed that carers did not always follow instructions in peoples care plans in relation to communication, for example ensuring they were wearing aids or communicating in a way to help them comprehend.
- At the last inspection we found pictorial information had not been given consideration as an alternative to written words when the provider and staff presented information to people. At this inspection we found the provider had made improvements and introduced pictorial menus and activity timetables.

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

● We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Our evidence showed us staff did not take opportunities to engage with people unless this was task orientated communication, such as asking if the person wanted a drink.

● At our last inspection we found people did not always have access to activities and the range of activities was poor. At this inspection we found that this had improved, and people had been consulted about what activities they would like to take place at the home.

Improving care quality in response to complaints or concerns

● The provider kept a log of complaints and recorded the response to them. We saw people were satisfied with the responses.

End of life care and support

● Improvement was needed to ensure people's end of life wishes were reviewed and correctly recorded. We have further reported on this in the effective section of this report

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we found the providers governance and oversight of the service was not effective. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider's quality monitoring and auditing systems and processes consistently failed to identify where improvements were needed. For example, where hazardous substances harmful to health were stored in an unlocked room, the provider's checks had failed to identify the risks of avoidable harm.
● The provider's checks to ensure they had the legal authorisation to restrict a person's liberty had failed. Processes to ensure applications for renewed authorisation had not taken place as required by the Deprivation of Liberty Safeguards.
● The provider's processes to ensure people's DNAR and RESpECT decisions remained valid were ineffective. Whilst the provider had noted information on some was incorrect, they had taken no action to rectify this.
● The provider's and managerial oversight of staff at the home had not ensured people received the care and support they needed. For example, spot checks of people's mealtime support had not identified the shortfalls we found.
● The provider had failed to ensure safety checks at the home were being carried out appropriately to identify safety concerns and that where faults or concerns had been identified, corrective action was taken.
● The provider's systems of recruitment had failed to ensure all checks were consistently completed at the point of recruitment and also periodic checks during employment
● Care plans audits had failed to identify where improvement was needed to ensure care was personalised and all important information was recorded. For example, no checks had been completed by the provider to ensure protected characteristics under the Equality Act had been considered or recorded in plans of care.
● The provider had not ensured staff followed the General Data Protection Regulations. We found people's personal information left unattended by staff on a table in a communal lounge.
● The provider had failed to ensure they had effective environmental checks in place or that staff responsible for environmental checks had received the training needed to fulfil their delegated role. For

example, people were not protected from the risks related to legionella.
● Health and safety checks were ineffective. The provider had not ensured checks took place to reduce the risks of people falling from windows.

The providers governance and quality systems were not effective. This was a continued breach of regulation 17 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
● People were not always engaged or involved in how their care was planned or delivered.
● Staff told us that they had regular meetings to discuss the home and people living there. This included handovers at the end of a shift. However, we found this was not always effective as we found some people's needs were not met.

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
● Discussions with the acting manager, who was in the process of applying to become registered, demonstrated they understood their responsibilities under the duty of candour.