Prime Life Limited

Clarendon Beechlands

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

About the service
Clarendon Beechlands is a residential care home providing personal care to 18 people at the time of the inspection. The service can support up to 18 people who have a learning disability or autistic people, people with a mental health condition and younger adults.

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

Right Support: People did not receive the support required in a safe way. There was a shortage of staff, and not all staff were sufficiently trained. This meant staff were not always available to administer medicines, and staff did not understand their responsibility to report restrictive practices. This resulted in people experiencing unlawful restrictions on their daily life.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: People did not always receive care and treatment that promoted their human rights or encouraged and promoted their dignity and privacy.

Right Culture: A lack of leadership allowed a poor culture to develop within the service. Whilst most people were happy to live at the service, and provided some good feedback, the management did not effectively assess areas of safety and quality and facilitate any drivers for improvement. Some areas of the home were not cleaned thoroughly, and other areas needed decorative repair.

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 25 September 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

Enforcement
We have identified breaches in relation to risks of abuse and harm to people, poor upkeep of the building, a lack of staff and a lack of leadership 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 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 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 always effective.

Details are in our effective findings below.

Requires Improvement

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 responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Clarendon Beechlands

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by 2 inspectors and an Expert by Experience. 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
Clarendon Beechlands 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. Clarendon Beechlands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 January 2023 and ended on 27 January 2023. We visited the location on 23 January, 24 January and 25 January 2023.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 13 December 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We sought the views of 9 people living at the service and heard comments from 4 people's next of kin. We spoke with 17 staff including the registered manager, regional director and associate director. We reviewed a range of records including care plans, risk assessments, medicine records, audits, policies and procedures, training data and recruitment information.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse and improper treatment. One person had suffered a decline in their mental health and had placed themselves at risk of harm. Restrictions were imposed on the person, however an application to have this restriction added to the provider's legal authority had not been submitted. This meant the person was restricted without legal authority.
- When the person was discharged from hospital, their care plan recorded they were 'mentally well.' However, these restrictions were not reviewed or revoked, and continued to be in place. This meant the person's human rights were not consistently upheld.
- We sought feedback from 14 support workers. Each of them told us they knew how to raise a safeguarding concern. During the period where the person was being deprived of their liberty without the correct authorisation, none of these staff raised a concern and did not challenge their colleagues on poor practices. This allowed the improper treatment of this person to continue for an extended period of time.

Staff were not aware of their responsibilities to prevent, identify, and report abuse. The deprivation of a person's liberty for the purpose of receiving care or treatment without lawful authority was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people were not always managed safely and proactively. Some people were at risk of harm in the event of an emergency because their evacuation plans were not reflective of their needs. Several people were identified as being potentially unwilling to leave the building in an emergency due to their mental health conditions. There was no information for staff on how to manage this, or what action to take should the person refuse to leave the building. This meant people's safety and welfare was at risk of being compromised in the event of an emergency evacuation being required. We raised this with the provider, who took swift action and amended people's evacuation plans to reflect their needs.
- A review of accidents and incidents identified 11 occasions where staff members had been harmed from people living at the service. This included people grabbing staff and digging their nails into their skin, a staff member being punched in the head, an incident where a person intimidated a staff member and intimated the threat of strangulation, and 2 occasions where staff members had been touched inappropriately. Action had not been taken following these incidents, such as providing additional guidance and support for staff members on how to respond should these incidents occur again. This placed other people living at the service at potential risk of hostility or aggression.
- Risks to people with diabetes had not been properly assessed and mitigated. We reviewed 3 care plans and found they all had diabetic care plans in place. However, they failed to contain guidance for staff on how to identify and manage symptoms of low blood sugar. This placed people at risk of a hypoglycaemic

attack. There was also no information advising who was responsible for monitoring people's blood glucose levels and how frequently this should be completed. This placed people at risk of becoming unwell as staff did not have sufficient guidance in place.

Risk to people was not being fully assessed and mitigated as much as possible. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. Records for people's 'as required' medicines protocols were either missing or not complete. For example, 1 person was prescribed medicines for pain relief, and to help with sleep. No protocols were in place. Another person had been prescribed a type of pain relief medicine. The protocol for this did not describe how much time needed to be left between doses, meaning an error could have been made when staff administered this. People were at risk of avoidable harm as staff did not have enough information to administer these safely.

● Risks relating to blood thinning medicines were not considered or recorded. One person was prescribed an anti-coagulant medicine to thin their blood. Staff confirmed there was no risk assessment in place, when the document was requested. This placed people taking anti-coagulant medicines at risk of becoming unwell, due to staff not having guidance on the risks associated with blood thinning medicines.

● Risks relating to the non-administration of medicines was not documented, and there was no guidance for staff. For example, some people drank alcoholand there was no provision for this on their medicine care plan. This meant there was no detail for staff to follow if a person declined their medication, or it was unsafe to administer the medicine, and at which point this should be escalated to medical professionals.

Medicine records were not always accurate and risks with medicines had not always been assessed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Overall people received their medicines on time and when they needed them. Medication administration records were kept up to date each time a medicine was administered.

Preventing and controlling infection

● People were not always protected from the spread of infection. Mask wearing for all staff was still being implemented as per the provider's policy. However, we observed multiple occasions where staff were not wearing masks or wearing them incorrectly. This included the registered manager, regional manager and associate director.

● Areas of the home were not kept clean. Mould was found growing in en-suite wet rooms in bedrooms belonging to 3 people. This was particularly around the shower area. This placed people at risk of inhaling mould spores which could make them unwell.

● Wooden handrails leading upstairs and around the upstairs landings had chipped paintwork and displayed ingrained dirt. The chipped paintwork exposed porous wood which could not be readily cleaned or sanitised.

● We reviewed cleaning records and found they were not always completed, to evidence deep cleans of people's bedrooms and ensuites, or evidence regular cleaning of high touch areas.

The failure to ensure that people were protected from the spread of infection is a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff deployed to meet the needs of the service. No domestic or catering staff were employed This meant support staff were expected to cook, clean and support people, impacting on the completion of these tasks. Staff told us the service was short staffed, and predominantly staffed by bank staff.
● There were not enough numbers of medicines trained staff deployed to ensure people could receive their medicines in a timely way. Not all of the night staff had current training in medicines, meaning on some nights, people could not receive their medicines after 8pm once the day staff had finished their shift. The provider's staffing rotas demonstrated this has occurred on 8 occasions during the month of January 2023.
● Staff were not always recruited safely. Some staff files were missing recruitment checks and 2 staff had expired Disclosure and Barring Service checks in line with the provider's own policy. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Since the inspection, the registered manager confirmed the 2 staff have had new DBS applications submitted.

The provider's failure to deploy enough, safely recruited staff to meet the needs of people at the service was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
Relatives told us they were welcomed into the home to visit their loved ones. The provider advised there were no restrictions on visiting, and the visitors book demonstrated visitors were able to come and go as often as they liked.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff were not competent in all areas of care delivery. Medicines competency checks were found to be out of date for all 7 members of medicine trained staff. All competency checks were more than 6 months old, which was not in line with the provider's own policy. This meant people were supported with the medicines by staff who had not been recently assessed as working within national guidelines.
- Training data supplied by the provider also demonstrated multiple staff had not completed training, or their training had expired in some areas. For example, records provided showed 8 staff members had not completed or had expired training in fire safety, 9 staff members for first aid, 9 staff for moving and handling.
- Additionally, the training data provided showed 13 staff members did not have training in learning disabilities. From the 1 July 2022, all registered health and social care providers must ensure that their staff receive training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role.
- Staff told us they received an induction before starting, however, some of the staff with missing training had less than 12 months service. This meant they had not completed sections of training as part of their induction, as opposed to it having been completed and then expired. We were not assured the staff induction training was thorough enough, as the records the provider supplied did not demonstrate all staff had completed this before commencing employment.

Staff did not have the necessary training nor assessments to ensure they were competent to undertake their role. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Not all areas of the home were well maintained. There was a noticeable difference in the quality of décor and furnishings downstairs, compared to upstairs. For example, upstairs bedroom doors were observed to be heavily scratched and had chipped paintwork. The registered manager advised they had a set decoration budget each year, and they had opted to spend the most recent budget on upgrading the downstairs areas of the home. The upstairs of the home was due to be completed with the next decoration budget provided.
- Some maintenance tasks were required in people's bedrooms. For example, 1 person's toilet roll holder in their ensuite wet room was missing, leaving the fixing bracket attached to the wall. This posed a skin tear risk, should the person catch their limb on this whilst using their wet room.
- Other issues identified included a broken toilet flusher button and limescale build up in the toilet pan, a ripped mattress cover and a patch of plaster missing in another person's ensuite wet room. This meant the

current maintenance process was ineffective at identifying and resolving the issues found during the inspection.

The failure to keep premises adequately maintained was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The garden was accessible and had outdoor seating available. The garden was tidy and was used often, mainly by people living at the service who smoked.

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.

● People were deprived of their liberty without lawful authority. This impacted on people's freedom and privacy.
● People's DOLS authorisations had not always been used to inform other aspects of care planning. For example, 1 person was unable to leave the home unaccompanied, due to the risk of disorientation, inability to reliably identify dangers and hazards placing them at risk of immediate harm through cold weather or road traffic accident, and their high level of vulnerability would make them an easy target for abuse. This had not been described in their personal emergency evacuation plan, which made no provision for the person to remain accompanied by staff at all times in the event of an evacuation from the building and onto the street. This placed the person at risk of harm or injury as this information had not been included across other documents within the person's care records.
● Records of a person's refusal to engage with conditions of their DOLS authorisations were not clearly recorded. For example, 1 person had conditions in place which stated the provider must take them to their place of religious worship, and to medical appointments. It was known that the person would persistently refuse to leave the service, which made it difficult for the provider to meet the conditions set. However, this was not clearly documented.
● Mental capacity and best interest decisions had not always been made where people lacked capacity. For example, 1 person posed a risk of setting a fire within the building, endangering the lives of all at the service. The decision had been made to restrict the person's access to cigarette lighters, however no capacity assessment or best interest decision had been completed.

The service did not act in accordance with the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11 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

● People's care plans did not always reflect best practice guidance for staff to follow. For example, a lack of information regarding how staff should manage a person's refusal to take their medicines. This is described in the NICE guidelines on managing medicines in care homes.

● Care plans were found to contain conflicting information. One person was at risk of not returning home at a reasonable time. One of the pages stated the person had a curfew of 8pm, however another page described how the person did not have a curfew. This inconsistent information meant it was difficult for staff to follow the missing person's procedure as it was not clear in records whether the person should be home at a certain time, or not.

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

● Food allergies were not always well documented. One person had a range of dietary allergies, however some of their care records did not describe how staff should identify any potential allergic reaction, or how they should respond to this.

● Only a simple breakfast and a light evening meal was prepared in house by staff members. The main meal each day, a hot lunch, was delivered from a centralised kitchen. This meant there was a set amount of food available for people. One person commented, "[The staff] don't let you have seconds and there are no cooked breakfasts; it is cereal or toast."

● Feedback from people was mixed regarding the provision of food. One person told us, "I rate the meals as 7 or 8 out of 10."

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

● People had access to healthcare support when required. For example, 1 person had swelling on the back of their legs and feet. Staff sought medical advice and the person made a full recovery.

● A chiropodist visited regularly, and people received regular foot care. Opticians visited to keep people's eyes healthy, and people had records of trips to the dentist.

● Staff supported people to attend appointments. One person said, "[Staff] take me to the doctors, I pay for the petrol. I also go to [named place] for [medical treatment]."

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 good. At this inspection the rating has changed to 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

- People's privacy and dignity was not always respected. We found 1 person who had been living with unnecessary and unauthorised restrictions on their life for a substantial amount of time. The registered manager was unclear about the restrictions imposed and had to seek verification from a staff member. The registered manager responded to our concerns, and immediately stopped the unauthorised restrictions for this person.
- Staff were observed to knock on people's bedroom doors, and to seek consent before entering.

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

- People were not always well protected from the risk of racial abuse. One person had been racially abusive to another person on 3 separate occasions. Whilst further incidents had not been recorded as occurring, other people and staff were at risk of being targeted due to their race. The person's care plan and risk assessments had not been updated to include the potential threat of racial abuse towards others. This meant there was a lack of suitable guidance to support staff to manage the incident, should it occur again.
- We saw one example of managers and staff promoting the acceptance of difference. This person was encouraged to live their life on their terms and express themselves in a way which they chose. This promoted diversity within the service.

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

- People were not always supported to be involved in decisions about their care. One person using the service had agreed to participate in goals being set each month for them to achieve. The reviews of these goals recorded staff stating the person had not met their goal, however, there was no investigation into why this was, or how staff could support the person to achieve this. The person had not been consulted in relation to this. The same goal was then set repeatedly for following months, each time the review concluded the person had failed to meet their goal.
- Some people living at the service had chosen not to participate in goal setting activities. Their choice was respected by staff.

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 good. At this inspection the rating has changed to 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

- The management of support offered to people to encourage them with relationships that meant something to them, was not always sufficient. Where it was difficult to establish people's understanding of relationships and their capacity to consent to these relationships, conversations had not always taken place with people around this element of their life.
- The documentation of relationships was not always recorded in a dignified way. Where there was a relationship between people living at the service, records read in a prescriptive way and did not always demonstrate the provider had always respected people's choices.
- Weight loss concerns were not always actioned and followed up. One person's records identified they had lost an amount of weight; however, they were then not weighed again in accordance with the provider's process. No actions had been recorded in response to the weight loss concerns.

Improving care quality in response to complaints or concerns

- People's feedback regarding verbal complaints was mixed. Some people told us that comments or suggestions they raised at meetings were not actioned. One person said, "Nothing changes after the meetings."
- A complaints procedure was in place and people understood how to make a complaint about their care.
- A review of the provider's complaints folder showed some low-level complaints had been received. Records showed these complaints had been dealt with efficiently.

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

- There was a good mix of activities and people were observed to participate in the activities, such as karaoke, and dominoes. There was a pool table available for people to use as they wished in a separate lounge. One relative commented they felt the activities were very good and knew that their relation took part.
- People were supported with their choice of day centre or go out to places of their choosing with staff support if this was required. One person was keen to frequently visit their place of religious worship, this was acknowledged and supported by staff.

End of life care and support

- At the time of inspection, no one living at the service was at the end of their life. However, provisions had been made for 1 person. A personalised funeral plan was in place, and the provider had taken the time to seek the person's preferences regarding their choice of music, flowers, and style of coffin.

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.

● At the time of the inspection, no one had any specific communication needs or aids. One person often spoke very quietly, and staff were observed to take the time to listen closely to what the person said to ensure they could communicate with them.
● Visual display boards were located downstairs which provided a variety of information for people.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

- The provider had failed to operate effective quality assurance systems to assess and monitor the safety and quality of people's care. Audits were not robust and failed to adequately identify and address shortfalls in the safety of the service, including, but not limited to, medicines management, care planning and risk management, staff training and recruitment practices.
- Systems to ensure accurate records were available to support staff to evacuate people in the event of a fire were not effective. Whilst the registered manager and regional manager amended the records once this had been raised, this was only as a result of the inspection occurring and prompting this.
- We were not assured the registered manager had sufficient oversight of the service. For example, they had to check with another staff member as they were unaware these restrictions were in place. One relative told us, "The manager is never there." One person told us, "I don't know who the manager is."
- There was a failure to respond to known risks. For example, the external water contractor had advised the provider to complete more tap descaling to prevent the build-up of limescale which could harbour bacteria. Evidence could not be provided if this had been completed, and limescale build up was observed on some taps.
- The recording and reporting of risks and incidents was inconsistent, and action had not always been taken to prevent reoccurrences, such as care plans being updated to provide staff with additional guidance.
- The registered manager told us they understood their role in relation to the duty of candour, and their duty to report certain incidents on statutory notifications to us. However, we identified a significant number of incidents which required a notification submitting to ourselves, but these had not been submitted.

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

- There was a lack of leadership within the service. The provider and registered manager were unaware of all the issues within the service. This had allowed a culture of some poor practices to develop and continue. The registered manager told us they had not overseen everything, and stated they, "Needed to be more on the ball."
- Equality, diversity and a human rights approach were not always given priority. Racial abuse was not always appropriately managed at the service and a breach of a person's human rights was uncovered during the inspection.

Failing to assess, monitor, and improve the quality and safety of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Records were not always completed contemporaneously regarding the care people had received or declined. This impacted on the provider being able to provide accurate information to healthcare professionals and allow cohesive working.
- Relatives had mixed feedback on how they were engaged. One relative was not satisfied with the overall care of their loved one, however another relative spoke very positively of the support their relative received.
- People's feedback of living at the service was good. One person told us, "The best thing about here is there are no worries about anything." Another person told us, "I like it because I have got support behind me. I know that I am loved."
- Residents meetings took place on a monthly basis. Most people chose to attend these meetings. One person stated they enjoyed the meetings and found them valuable.
- Staff told us they felt listened to and included. One staff member said, "I receive support from management and regular conversations with management about how I'm finding work and if I have any worries."