Drake Court Healthcare Limited

Drake Court Residential Home

Inspection report

Drake Close
Bloxwich
Walsall
WS3 3LW
Tel: 01922 476060
Website: No Website

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 17 and 18 November 2015 and was unannounced. At the last inspection completed on 14 October 2014 we found the provider was not meeting the regulations regarding the safety and suitability of the premises and also safe care. At the most recent inspection we found that further improvements were required.

Drake Court Residential Home is a care home that provides accommodation for up to 29 older people who require personal care. At the time of the inspection there were 28 people living at the service, some of these people were living with dementia. The service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered

Summary of findings

persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection there was not a registered manager in post. A new manager had joined the service during the week prior to the inspection and we were told they would be completing their registration with CQC.

People were not protected from potential abuse or inappropriate treatment. The provider did not have adequate procedures in place to ensure that concerns were identified, reported and managed effectively.

People were not always protected by effective risk management or safe practise around supporting people to move without risk of harm or injury. People told us that they were happy with the way they received their medicines. We found that medicines weren't always stored appropriately.

Staff recruitment practices had been improved by the provider ensuring that people were supported by staff who had the required pre-employment checks completed. People felt there were sufficient numbers of staff available to support them.

People's human rights were not always supported by their consent to care being obtained in line with current legislation. Principles of the Mental Capacity Act had not been followed. People were not supported by staff who felt sufficiently trained to fulfil their roles effectively.

People told us that they enjoyed the food and drink that they received. People told us that their day to day health needs were met and people had access to external healthcare professionals.

People's privacy, dignity and independence was not protected by staff in the way that care was provided and people were communicated with. Some people told us that they were able to make choices around the care they received. However, this practice was sometimes inconsistent across the service.

People told us that they weren't involved in planning their own care. People's care plans did not always reflect their needs and preferences and staff weren't always aware of people's needs. People told us that they did not always have access to leisure opportunities that met their preferences.

People told us that they knew how to complain if required. The provider had failed to establish systems that monitored and improved the quality and safety of the service provided to people. The provider had also failed to establish systems that monitored and managed risks to people.

Feedback about recent management changes were positive. Staff felt that the new manager would make the required improvements within the service and they recognised areas requiring further improvements.

We found that the provider was in breach of some regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

People were not protected by systems that would identify potential abuse or improper treatment. People were not always supported by effective risk management.

People were happy with the way they received their medicines although storage was not always appropriate. People were supported by sufficient numbers of staff who had been fully checked before they started work.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were not always supported by staff who were trained sufficiently to be effective in their roles. People's human rights were not as consent was not always obtained in line with current legislation.

People were happy with the food and drink they received. People's day to day health needs were met.

Requires improvement

Is the service caring?
The service was not consistently caring.

People's privacy, dignity and independence was not always supported through care practices and staff communication. Staff interactions were not always caring.

People felt that they were sometimes involved in choices about some aspects of their care.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not supported to receive care that was personalised to their needs and preferences. People were not effectively involved in their care planning and reviews. People did not always feel that there were sufficient leisure opportunities.

People told us that they knew how to complain if require. People's concerns had been addressed when received but their feedback had not been proactively sought.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

People were not protected by effective managements systems that identified and managed the risks to people and the quality of service received.

Requires improvement

Summary of findings

People were supported by a staff team that had not always been managed effectively. People's experience within the service had not been improved through effective governance and leadership. However, staff told us that they felt positive about recent changes in management and the new manager recognised areas requiring improvement.

Drake Court Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 18 November 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor and an expert by experience. The specialist advisor was a qualified nurse who has experience working with older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with nine people who lived at the service. Some people who lived at the service were unable to share their experiences so 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 spoke with the owner, the general manager, the service manager, the cook, four care staff, two visiting health care professional and two visitors who were relatives of people living at the service. We reviewed records relating to medicines, three people's care records, four staff files and records relating to the management of the service. We also carried out observations across the service regarding the quality of care people received.

Requires improvement

Is the service safe?

Our findings

At the inspection completed in October 2014 we found the provider was not meeting certain legal requirements. These were the regulations regarding the safety and suitability of the premises and also the safe moving and handling of people. At this inspection we found that the provider was meeting the requirements of the law in these areas, however, further improvements were required regarding safe moving and handling of people living at the service.

Prior to the inspection we were made aware the provider was not always reporting safeguarding concerns to the Local Authority (LA). The LA takes the lead in investigating and responding to allegations of abuse. During the inspection we asked the provider for records relating to any safeguarding referrals that had been made but these records were not available. During the inspection we heard someone tell a member of staff that they had been treated inappropriately by another member of staff. Despite staff telling us that they knew how to protect people from the risk of abuse, the staff member failed to report these concerns and had not recognised their responsibility to do so. We were told that the person had previously raised concerns about this staff member. The provider had also not recognised the need to report these concerns to the LA and therefore they had not been investigated under the LA's safeguarding procedures. The provider had also failed to send notification of these concerns to CQC as they are required to do by law. A manager at the service submitted a safeguarding referral to the LA during our inspection regarding the incident we observed.

Due to concerns around the way the provider managed the incident we observed, we asked to see the provider's safeguarding policies and procedures. The policy was out of date and did not reflect current legislation and best practice guidelines. The provider advised that a new policy had been obtained, however, this had not yet been implemented or made available to staff. Effective systems and processes had not been established and operated to protect people from the risk of abuse.

This was a breach of Regulation 13 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

We looked at how the provider managed risks to people living at the service. We observed some unsafe practices relating to moving people in a way that increased the risk of injury or harm to them. For example, we saw that a mobile hoist was used in areas with very restricted space in the lounge. We saw staff members not fully focussing on people that they were transferring and having conversations with other staff and visitors. We also saw people being supported under their arms when standing which can increase the risk of injuries such as tripping or skin damage. Although risk assessments had been completed by the provider, they did not always reflect people's individual needs. This meant that robust guidance was not always available to staff on how to minimise risks to people. The manager advised that risk assessments were under review as they were not always currently reflective of people's needs.

We saw that a summary of accidents was recorded and monitored by the Head of Senior Care. This had resulted in intervention being sought from the falls prevention team for one person. People told us that they had received support following falls. One person told us, "I felt safe because they make sure I don't fall over although I'm quite mobile". Another person said, "A [person] fell over some time ago and the staff helped [them]". We saw however, that accidents were not consistently recorded. We looked for accident records relating to specific incidents with the manager in order to identify the actions that were taken to manage the risks. We were unable to locate some of these records, therefore, we were not able to confirm if appropriate steps had been taken to manage the risks relating to these events.

We looked at how people were protected through the safe storage and management of medicines. Most medicines were stored securely, however, we did find topical creams that were not securely stored within people's own rooms. We found that there were medicines stored in a fridge that was recording a temperature higher than the recommended manufacturers guidelines. We found that despite advice having been sought from the pharmacy no action had been taken to rectify this. We spoke with the manager about this and they took action to resolve this matter. On the second day of our inspection fridge temperatures were within an appropriate range.

People told us that they received their medicines every day. One person said, "I have to take loads of medication which

Requires improvement

Is the service safe?

the staff give me every day." Another person said, "I have my medication at the same time every day." We saw that practices around administering medicines were safe and medicines given were recorded in people's medicines administration records. We found that stock levels of people's medicines matched the records outlined within their records. Not all staff that we spoke with were aware that people might need 'as required' medicines or how to identify when these should be given. We found protocols that explained when people needed their 'as required' medicines were not in place. We found that although there were staff trained to give people their medicines, there were circumstances where no trained staff were available, for example at night. The manager advised that further medicines training was being arranged for staff.

We looked at the providers practices relating to recruitment and pre-employment checks for staff. Two of the staff files we reviewed were for staff members who had started work over 12 months ago. We found that their pre-employment checks had not been completed before their employment began. The provider told us that they had identified this concern and had taken action to improve their recruitment practices. We reviewed two staff files for staff members who had been recruited in the three months prior to the inspection. We found that all pre-employment checks were now being completed before staff members were able to start their employment at the service. People told us that they felt there were sufficient numbers of staff. One person said, "I think there's enough staff to care for me." Staff told us that they felt there were sufficient numbers of staff available to support people effectively and this reflected what we saw during the inspection.

Requires improvement

Is the service effective?

Our findings

People did not always receive care and support with the appropriate consent being obtained. We saw examples of where staff obtained people's consent, however, we also saw care being provided without consent. We saw examples where care staff told people what they were going to do but failed to obtain consent. For example, on the first day of the inspection we saw care staff wipe someone's hands and mouth without obtaining consent. On the second day of the inspection we saw care staff comb someone's hair without consent and say, "I'm going to get my trimmers" indicating that they would cut the person's hair.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that where people lacked the capacity to make decisions about, or to consent to the care they received, the principles of the MCA had not been followed. For example, we found that one person had a sensor mat in place in their bedroom to alert staff to their movement due to them having a high risk of falls. Staff told us that the person did not have capacity to consent to this and we were told by staff that the person kicked the mat under their bed as they didn't want it in place. The provider had not followed the principles of the MCA in carrying out a mental capacity assessment to make this decision and no consideration had been given to whether this was in their best interests. In addition, we found that in the last month this person had refused 10 doses of their pain relief medicine. The provider had not recognised that this person may have lacked capacity to refuse their medicines and followed the principles of the MCA to ensure decisions about medicines were made in their best interests.

We found other examples of the appropriate consent not having been sought and the MCA not having been followed. We saw an example of one person being given three medicines covertly by staff crushing them and adding them to their food. We found that another person was refusing treatment and appropriate alternatives had not been considered. We saw that several people were highlighted in their risk assessments as requiring continual supervision although their consent had not been obtained. There were no assessments of capacity completed in line with the MCA for people who lacked capacity to make these decisions. We also confirmed that staff had not received sufficient training in this area. The training record provided by the manager showed 16 out of 20 members of staff recorded as not having been trained in the MCA. The provider had not acted in accordance with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found examples such as people being under continuous supervision within the service. The provider was not able to confirm if they had made any applications to the local authority to deprive people of their liberty. The manager made contact with the local authority during the inspection to obtain records of any applications that had been submitted.

Staff told us that they had not received sufficient training in order to effectively carry out their roles. We were told that the Head of Senior Care had recently begun to arrange training for staff members since the last manager had left the service. Staff told us that the new manager was supportive of improving staff training and was organising training courses. We reviewed the current training records and found they were incomplete or inaccurate. For example, 16 out of 20 members of staff had incomplete or out of date moving and handling training. In addition, 15 members of staff had not received safeguarding training. We saw this lack of training reflected in the care practice that we observed, for example with unsafe moving and handling practices. We were told by staff that the Head of Senior Care had recently started completing supervision meetings with staff following the departure of the last manager. Staff told us that it had been several years since they had last had a supervision with their supervisor. The

Requires improvement

Is the service effective?

new manager told us how they planned to develop the training and induction programme for staff members in order to ensure that people received good standards of care.

People told us that their day to day health needs were met and they had access to healthcare professionals when needed. One person told us, "If I need to see my doctor, staff will arrange this for me." Another person told us, "I can see my optician and chiropodist when it's needed." We saw that one person's health had recently declined and support was being obtained from the community nursing team and the person's GP. The outside healthcare professionals that we spoke with told us that staff always actioned what was asked of them in order to support people's health needs. Communication books were used to highlight any health concerns that required monitoring by staff or any actions that were required to support people. We saw that in most areas staff were proactive in monitoring people's health needs and seeking support from outside professionals as needed. However, when we looked at records we could not always see when people had last seen professionals such as the dentist. The new manager had recognised this and was developing a new method of recording and monitoring people's healthcare appointments.

People told us that they enjoyed the food and drink that they received. One person told us, "The food's good and plenty of it as well", another person said, "The food's very nice and I can pick from the menu when she comes around." A new cook had recently been appointed and told us that they were committed to providing good quality food and giving people choice. We saw that people were given a choice of meals and that alternatives would be provided when requested. We saw that meals were cooked freshly on the premises and were well presented. The cook and care staff were aware of some people's dietary needs; for example one person required a gluten free diet and another person required a soft diet. The list that the cook held in the kitchen of people with diabetes did not match the record held in the central office. Staff also were not consistent when speaking with us as to how many people were living with diabetes and records held within the service were not consistent. We could not be certain that the dietary needs of these people were being met. The new manager identified that nine people were diagnosed with diabetes immediately following the inspection and resolved this issue.

Requires improvement

Is the service caring?

Our findings

People told us staff did not always speak to them in a dignified way and we saw that their confidentiality wasn't always upheld. One person told us, "Sometimes when they are getting me up they are in a rush and they speak to me sternly but they don't mean anything by it." Another person told us, "The staff sometimes shout at other people if they won't do as they ask them to." We observed numerous situations where staff spoke to people abruptly or did not speak to people in a way that promoted their dignity. We heard staff use comments such as, "[Person's name], don't use your fingers", "[Person's name], don't you take off" and "You need a haircut don't you [person's name]". We heard one staff member talking to a visitor about someone who was not related to them, which breached their confidentiality. We heard an example of one person refusing care. Staff had a confrontational conversation with this person about the situation in a communal area. We then heard staff discussing this refusal with other staff members openly in a communal area. People's privacy was not always respected.

People were not always supported in a way that promoted their dignity and independence. For example, we observed examples of people being transferred in a hoist where staff were not focussing on the person they supported. We saw people suspended in the hoist and staff talking to other staff members and visitors in nearby areas while the person remained suspended in the hoist. Care staff were not always ensuring that the person was reassured and communicated with effectively during these transfers and people were left in the hoist for sometimes longer than necessary. We saw one person crying when staff attempted to transfer them. We were told by staff that this person often cried when they tried to support them to move. We observed staff providing insufficient reassurance to this person. We looked at this person's care plan and there was no reference to them becoming upset during transfers or guidance as to how to minimise this person's upset. Staff had not ensured that people were fully respected and their dignity promoted while they were supported to move.

We saw that people's dignity and independence was not supported effectively during meal times. Several people were unable to cut up their own meals and care staff adopted a practice of standing over the person and cutting up their food in communal areas. Staff told us that they had not considered methods, including the use of adaptive cutlery to promote people's dignity and independence. We saw that staff were sometimes completing other tasks for people where their independence could be promoted. For example, we observed staff pouring milk for people without supporting people to complete these tasks independently. We saw several examples of people's dignity being compromised due to staff not ensuring they were supported to wear clean clothing. Four examples were observed of where people had food residue on their clothing, some of which were observed over a period of several hours.

Some people did tell us that there were areas of their care in which they could make choices. One person said, "They ask me what I want them to do for me." We saw one person struggling to decide where to sit in the dining area and apologising to the care staff supporting them. The member of staff was heard saying, "You don't have to be sorry, it's your choice". Staff told us that they offered choices to people but this was not always reflected in the practice that we observed. For example, we did not observe people being given the choice around whether they did or did not wear clothes protectors during mealtimes. We saw at lunchtime people were given a cold drink but were not offered an alternative. We saw an example of one member of staff having jugs of two different flavours of squash to offer people. We saw that they picked up just one flavour and poured this for everyone sitting at the table.

Some people told us that they were very happy with the care staff and the care that they received. One person told us, "It's a good caring home to live in". Another person told us "The staff are good and caring and they make me feel happy". Some people told us that they felt staff were too busy to take time to speak to them. One person said "I sometimes want staff to sit and talk to me but they are so busy". We observed a number of interactions between staff and people living at the service that were task oriented and not warm and caring. Staff did not always take time to speak to people or to explain what they were doing while they were providing care.

We saw that people were supported to maintain relationships that were important to them. Relatives and other visitors were able to visit the service without restriction. Relatives told us that they were happy with the care people received. One visitor told us, "I'm glad about

Requires improvement

Is the service caring?

the care that my relative gets from the staff, they are kind and helpful." Another visitor told us, "Staff are welcoming and make sure I'm told of any changes that have happened".

Requires improvement

Is the service responsive?

Our findings

We saw that people did not always receive support when they wanted it and care plans did not always reflect their needs. On the second day of the inspection we saw one person refusing to eat a meal due to not having been supported to shower that morning. Care staff offered the person a shower in the afternoon but failed to recognise that the morning shower was important to this person. They were heard telling the person that their "book" determined on what day this person had a shower in the morning. Another person told us that they wanted more flexibility to get up later if they had a poor night's sleep and this flexibility was not available to them. People's care was not being delivered in a way that always met their individual preferences and needs.

People told us that they weren't involved in planning their own care. One person told us, "I don't know anything about my care or if it's written down. I don't remember anyone talking to me about it." Another person told us, "Nobody talked to me about what I need or what care I needed. I have a slight disability to contend with as well." We looked at this person's care plan as we saw that they were having difficulties eating at lunchtime. They were not able to clearly see their cutlery and meal. Their care plan did not include the support that this person needed with their meals. Staff that we spoke with also confirmed that they had not yet identified the support this person required as they had only recently moved into the service.

People were not supported to be fully involved in the review and development of their care plan. We looked at the reviews completed for one person who was identified as needing additional support to make decisions around their care. This support, however, had not been made available during the review process. This person's care plan was marked as "plan remains the same" and did not outline the changes required in their care following a diagnosis of dementia. Staff told us that this person exhibited behaviour that could challenge others, however, they were not able to effectively describe the triggers of this behaviour. Strategies to effectively support this person with any challengeing behaviour were not outlined in their care plan. The provider had failed to ensure that this person's care plan effectively identified their needs and any changes in these needs.

Staff were not always aware of people's individual support needs. For example, we were given inconsistent information from people, the staff, cook and manager about who required support to manage their diabetes. After our inspection, the manager confirmed the number of people living with diabetes. Staff knowledge, care plans and records within the service did not always reflect the needs of those who required dietary support to manage their diabetes. Due to this confusion, people's needs may not have always been met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-Centred Care.

People told us that they did not always have access to leisure opportunities that met their needs and preferences. One person told us, "I can sit here and that's about all there is to do." Another person told us, "The carers are really busy and don't have time to talk to me which is sad." Another person said, "We don't have a lot. We have bingo". Staff told us that they felt they had improved the activities that they offered to people. Staff told us that they'd recently held a party for Halloween. The Head of Senior Care had recently begun to develop an activities programme. However, further work was required to ensure that people had sufficient activities to complete on a day to day basis.

People told us about a recent trip that had taken place. We were told, "Last week about eight of us went to the [place name] which was a nice break from the home." Another person told us, "They took us out last week to the big shop to look at the Christmas trimmings." Staff told us that they had fundraised to allow this trip to happen. We saw that staff had organised a Christmas raffle in order to raise funds for another outing in the New Year. On the second day of the inspection we saw people enjoying a visit from the hairdresser. People were singing together while they were waiting for their hair to be cut. We saw that people were supported to continue to observe their religious beliefs while living at the service. We saw that people were supported to visit places of worship and others received visits from members of their church. People told us that they enjoyed their trips out and the visits that they received from external people, such as the hairdresser and members of their church.

People told us that they knew how to complain if they needed to. One person told us "If I'm concerned about anything I would talk to the staff but I'm not concerned

Requires improvement

Is the service responsive?

about anything just now". Staff confirmed that they received complaints and either a senior carer or a manager would deal with these. The Head of Senior Care advised us of the outcomes of recent complaints received. The provider was not recording complaints received into the service and the outcome of these complaints. The last recorded complaint had arisen over two years prior to the inspection.

The newly appointed manager had begun to create feedback questionnaires in order to proactively seek the feedback of people, relatives and staff about the service. Some completed surveys had begun to be received from staff members. The manager told us that they were going to use feedback provided to identify areas of improvement required within the service.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection there had been no registered manager in post since the start of September 2015. The Head of Senior Care had been covering managerial responsibilities in the absence of a manager. A new manager had commenced their employment during the week prior to the inspection and we were told they would be registering as a manager with CQC.

The provider had failed to establish systems that monitored and improved the quality and safety of services provided to people. They had also failed to establish systems that effectively monitored and managed risks to people. For example, we found that the provider was not able to confirm when an audit was last completed regarding medicines management within the service. They had therefore failed to identify and take action to resolve issues with the storage of medicines that we found during our inspection. We found other examples where the provider had not established effective governance systems in order to assess and monitor the quality and safety of the service. There were no robust systems in place to record complaints and feedback about the service and so areas for improvement had not been recognised or monitored. We found that accidents and incidents were not always recorded and monitored effectively in order to identify trends and areas in which risks to people needed to be managed. People's care plans and daily records were not being effectively monitored and checked to ensure issues were being identified and effectively managed. The provider had not identified that care plans or the care that people received did not always reflect people's needs. This resulted in confusion around people's health or support needs and therefore meant people did not always receive the appropriate support.

The provider had failed to develop systems to ensure that the training staff received was recorded accurately and monitored. They had also not ensured that staff were effectively supervised through regular reviews of their performance. This resulted in staff not always having the skills required to meet people's needs. The quality of the service provided to people was not improved through effective staff training and development.

We saw that the provider had not developed systems to ensure that policies and procedures were maintained, reflected current guidance and legislation and were communicated effectively to staff teams. The provider told us that a revised set of policies had been purchased last year but they had not been personalised to the service by the management or implemented. These policies were ineffective as they were not being used by the provider. Care practice and systems therefore did not reflect the new policies. The provider had not developed an effective system to ensure that the management within the service were effectively carrying out their role and fulfilling their responsibilities.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

People told us that they hadn't always been communicated with effectively around the recent changes in management. One person told us, "The manager left a few weeks ago. I don't know why and nobody has told me anything about it." Staff told us they had been communicated with regarding the change in management and they had the opportunity to meet the new manager. Staff were positive about the recent changes and one staff member told us, "I feel now at least I'm going to have someone backing me". Staff told us that they felt the new manager would make the required changes within the service. We were also told that staff felt supported by the interim management arrangements that had been put in place prior to the new manager joining. Staff told us, "I respect [Head of Care]. I can tell her anything and "[Head of Care] will pull people up when they need to be pulled up." We were told that staff and residents meetings had recently been restarted by the Head of Care. Staff told us that a meeting had been held recently with residents to discuss the colour that they wanted the lounge area to be painted. We saw that the colours suggested had been used. We saw that although the governance of the service prior to the inspection had not effectively identified issues and driven improvements within the service, people and staff had confidence in the new management structure. The new manager told us that they were committed to making the required changes in order to provide people with a good standard of care within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved effectively in an assessment of their needs and preferences and the care they received did not always reflect these needs and preferences.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's human rights were not protected through their consent being obtained and through the effective implementation of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected through effective systems that ensured concerns around practices that did not support their health, wellbeing and human rights were identified and reported appropriately

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected by effective governance systems that ensured the quality of service and potential risks were monitored and managed.