ANJ & ASH Care Ltd

Clevedon Court Residential Home

Inspection report

1-3 Clevedon Road
Weston Super Mare
Somerset
BS23 1DA

Tel: 01934621981

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08 May 2019
21 May 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

The service is registered to provide care and support for up to 22 people with learning disabilities, autism and older people. At the time of our inspection there were 20 people using the service.

People's experience of using this service:

People who needed to be kept safe through continuous supervision had left the home unobserved placing them at risk. Staff did not have access to guidance about actions to take if a person was missing from the service. Suitable action had not been taken to prevent a reoccurrence.

People were at risk from potential harm and abuse. Safeguarding referrals were not consistently made to the local authority safeguarding team when allegations of abuse were made, or incidents were witnessed in the service. Incidents were not investigated, or action taken to keep people safe. Unexplained injuries, including unexplained bruising, had not been investigated appropriately or referred to the local authority safeguarding team.

People were at risk of injury from hazards in the environment relating to poor maintenance. Risks from scalding water had been identified, however the risks had not been assessed or managed. The registered manager could not provide assurances or evidence about which taps had been fitted with temperature control valves. Some wardrobes had not been secured placing people at risk.

Some medicines prescribed 'as required' were not being managed safely to ensure people received these correctly.

Following the inspection, we wrote to the provider and registered manager requiring them to take urgent action to address these risks and protect people from further risks.

The environment had not been properly maintained and there were malodours in areas of the home. Decorating works that had been completed were of a poor standard. There were discarded items in the garden, including an old cistern.

People did not have consistent access to meaningful activities. The service had identified that this was an area for development and had taken actions to improve this, including ordering horse shoes for people to decorate and arranging for a performer to visit the service.

Staff did not consistently receive training in line with the provider's list of mandatory training. Staff were not

receiving regular appraisals as the registered manager had suspended them to focus on areas they assessed as more important. Staff were recruited safely and received regular supervision sessions.

There was a programme of quality audits and provider checks in place. However, these had not been used effectively as issues found by inspectors during the inspection were not recorded in the corresponding audit. Audits lacked detail and effective improvement plans had not been developed as a result.

There were not enough suitably qualified staff deployed across the service to meet the needs of people.

The service did not consistently submit statutory notifications to the Care Quality Commission.

We observed some kind and caring interactions between staff and people However, we also observed some undignified interactions between staff and people. People's wishes were not always listened to or acted on.

Questionnaires had recently been sent to people, relatives and staff. The registered manager was reviewing the responses received. No recent meetings for relatives or people had occurred. During our inspection a large team meeting took place.

The registered manager had responded to complaints in a timely manner and spoken with staff involved when required. Relatives told us they could approach the registered manager with their concerns.

Food looked appetising and people were offered a choice of meals. People and relatives spoke positively about food at the service.
Rating at last inspection: Inadequate (published March 2019)
At the last inspection we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We asked the provider to submit copies of monthly reports for areas of particular concern. The provider had been submitting this information to the Commission.

Why we inspected: This inspection was brought forward due to information of risk and concern; we received information that two people subject to Deprivation of Liberty Safeguards had left the home unobserved.
Enforcement: We identified five continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one continuing breach of the Care Quality Commission (Registration) Regulations 2009.

This inspection identified one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory responses to any 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'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Clevedon Court Residential 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of two incidents about people subject to Deprivation of Liberty Safeguards who had left the service unobserved.

Information shared with CQC about the incidents indicated potential concerns about the management of risk of people leaving the premises without necessary support. This inspection examined those risks.

Inspection team:
The inspection team consisted of three adult social care inspectors and one expert by experience. Two adult social care inspectors visited on each day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience's area of expertise were older people and people who have a learning disability.

Service and service type:
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
Inspection site visit took place on 07, 08 and 21 May 2019. The first and third days of the inspection were unannounced, the second day of the inspection was announced.

What we did:
We reviewed various records including, the training matrix, files for three employees, seven care plans, audits, and complaints. We spoke with 17 people who were using the service, three relatives and seven staff, including the registered manager, deputy manager and three care staff. We completed a tour of the service with the registered manager and deputy manager.

We made ten safeguarding alerts to the local authority safeguarding team about concerns identified during the inspection. We reviewed comments submitted by the registered manager after the inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- Referrals were not always made to the local authority safeguarding team as required. This included when allegations of abuse were made and when incidents were witnessed in the service.
- Unexplained injuries, including bruising, had not been investigated and referrals had not been made to the local authority safeguarding team.
- Actions were not taken to protect people from the risk of harm or abuse. For example, when staff identified that one person who had left the service unobserved at midnight, the police had not been called to help find the person.
- Staff were able to describe signs of abuse and actions they should take. One staff member said that potential indicators of abuse could include, "Unexplained, scared, nervous and unusual behaviour. However, there was no evidence any concerns identified were followed up.
- The local authority safeguarding screening tool was not used consistently and when used, it had not been used correctly. This resulted in a potential safeguarding incident where a person was punched to their chest, not being referred to the local safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Although people had previously left the service unobserved, there was no guidance for staff about what actions they should take if a person was found to be missing and may be at risk of harm.
- On the first day of our inspection, records of hourly checks for two people at risk from leaving the home without necessary support were completed retrospectively. At the end of the second day of our inspection, the records of hourly checks had not been completed by the time inspectors left. There was no confirmation that staff were aware of the whereabouts of people at risk.
- One-person subject to Deprivation of Liberty Safeguard had left the service through the garden. The garden remained unsecured at the time of the inspection and there was no risk assessment in place to minimise the risks of this reoccurring.
- Environmental risks observed during the inspection had not been identified by the service. For example, protruding nails, trailing wires, a hole in the floor of a communal shower room and discarded items in the garden, including a used cistern.
- People were at risk of scalds from hot water. Checks completed by staff had identified that water temperatures in en-suites for seven bedrooms, one communal toilet and the laundry room had exceeded safe levels. The registered manager told us that actions had been taken to make some of these taps safe. However, at the time of the inspection no evidence was available to confirm the action had been taken and

the registered manager could not tell us which taps had been made safe. There were no risk assessments in place to manage the risks posed to people by scalding water.
● The laundry was unlocked, with no staff present and accessible to people during both days of the inspection. We brought this to the attention of the registered manager who told us that the key used to lock the door had been taken.
● People were being assisted to transfer and stand after a fall with one of two communal handling belts. The registered manager confirmed that assessments for individuals using this equipment had not been completed and there had been no involvement from relevant professionals, for example an Occupational Therapist.
● Although one person had experienced a 'near miss' when an unsecured wardrobe fell forward, four unsecured wardrobes remained, and assessments had not been completed to identify the level of risk posed to people from a falling wardrobe.

Preventing and controlling infection
●Suitable actions had not been taken to ensure people were protected from the risk of infection.
● There were malodours in some areas of the home, the registered manager advised us that malodour in one communal bathroom was caused by an old waste pipe.
● Areas within the home could not be cleaned effectively because they were damaged. For example, flooring that was broken and exposed floorboards in one en-suite.
● Clean clothes in the laundry were stored next to dirty washing.
● We found four mattresses that either smelled strongly of urine or were urine stained and one mattress had faeces on it. Three of these mattresses did not have washable protective covers. We brought this to the attention of the registered manager and one mattress was replaced during our inspection. However, no protective cover was placed on this new mattress to prevent further infection control risks.
● Communal handling belts were being used to assist different people within the service to transfer and stand if they had fallen, this posed a risk of cross-contamination as they were not cleaned between use.
● There was equipment and furniture within the home with broken surfaces that could not be cleaned effectively.

Using medicines safely
● Medicines were not managed safely. We looked at the medicine administration records (MARs) for everyone living at the service.
12 people were prescribed 'as required' medicines (PRN). There were no protocols in place for any of these medicines to advise staff when these medicines could be given, the gap between doses or how frequently before seeking medical advice. Staff could potentially give medicines incorrectly.
●The MAR chart for this medicine had been handwritten by a member of staff. They had not signed it to identify themselves as writing this and it was not countersigned by a second member of staff as a check on accuracy.
●Some people were prescribed creams to help maintain good skin condition. There were no MARs in place for some people, or body maps to advise staff where to apply the cream. This meant the provider could not be sure these creams were applied as the prescriber intended.
●The provider's medicines policy stated any blood-thinning medicine should be highlighted on the persons MAR. Use of blood-thinners should be included in staff handovers and staff should call 999 if any person who was prescribed blood thinners fell. Staff were not following this policy which meant people were potentially at risk from unidentified internal bleeding.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On both days of the inspection we saw a member of domestic staff cleaning bedrooms and toilets.

Staffing and recruitment

● The service did not use a recognised staffing dependency tool to ensure that there were adequate numbers of suitable qualified staff deployed across the service. The registered manager told us told us they would increase the levels of care staff in line with changes in peoples' needs. For example, if a person needed end of life care.

● People were not receiving hours of funded one to one care and staff did not have enough time to complete social activities with people.

● People's care records were not always complete or up to date so a reliable assessment of their changing needs could not be made.

● Staff told us they would like to take people out but there were not sufficient staff to do this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Background checks of potential employees included a reference from the applicant's most recent employer, the applicant's employment history and photograph ID. The recruitment files we reviewed included a Disclosure and Barring Service (DBS) reference number. DBS checks are important as they help prevent the service employing people who may be unsuitable to work in care.

Learning lessons when things go wrong

● Lessons were not always learned when things went wrong. For example, one person had a 'near miss' when they pulled a freestanding wardrobe over. Although the wardrobe was fixed to the wall after the incident a review of the safety of furniture had not been considered. There were four wardrobes that had not been secured to the wall at the time of our inspection.

● The provider did not undertake effective analysis of accidents or incidents to identify themes or trends so that actions could be taken to prevent a recurrence. For example, at our last inspection people subject to Deprivation of Liberty Safeguards were leaving the service unobserved. At this inspection we found this remained unchanged.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance

- One person's Deprivation of Liberty Safeguards included conditions that required staff to accompany them to use the garden. However, the same person had used the garden independently and left the service unobserved. The condition of their DoLS relating to regular access to the garden was not being adhered to.
- Two people subject to Deprivation of Liberty Safeguards had left the service unobserved.
- One person's capacity had been assessed by the registered manager to determine if a safeguarding incident should be reported.
- The same person was deemed to be at potential risk of choking. They chose to eat in the lounge, however a decision was made that they should now eat in the dining room so that staff could monitor their eating. There was no capacity assessment or best interests' decision about this.
- Some people had door sensors and floor mats, but capacity assessments had not always been undertaken to check if the person was able to consent to this or if this was the least restrictive option and in their best interests.

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

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

- Throughout the service carpets were worn and stained. The carpet in one person's bedroom had been repaired with black tape.
- Since our last inspection, decorating had been undertaken. However, the decoration had been completed

to a low standard and there was minimal change. For example, one room had been repainted and a racing car border applied. The carpet had not been replaced, in one corner the coving was nailed to the top of the wall, the remainder of the walls did not have coving, and visible expanding foam had been used to fill a gap between the plug socket and wall.
● Flooring in peoples' en-suites was not always well fitted, clean or whole. For example, two flooring tiles in one person's en-suite were broken and exposed the floorboards beneath. Flooring in another person's en-suite had been repaired with silver tape.
● Furniture in peoples' rooms was, mismatched or broken. For example, there was a broken set of drawers in one bedroom, one person's wardrobe doors were being held closed with a plastic band and handles that were missing from fitted wardrobes had not been replaced.
● Exposed pipe and mains water taps remained in areas throughout the service. For example, in one person's en-suite there were two sets of exposed pipes with two mains water taps next to the toilet.
● A shattered tile in the communal shower room had been covered with a plastic tile, the shattered tile was discoloured from dirt.
● Protruding nails were found on wardrobes in two peoples' bedrooms.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke about our findings with the registered manager who told us flooring had been ordered however the decoration had to be completed first.

Staff support: induction, training, skills and experience
● The registered manager confirmed that not all staff completed or had up-to-date training in line with the service's 'Mandatory training list'. For example, nine care staff members had not completed their annual manual handling training.
● The provider could not always determine when a staff member's training was due for renewal because the training record did not always include this information. For example, "Cert 2018" was recorded and so the provider was not clear about how much time had lapsed since the staff member had received their training. One relative said, "I'm not sure about staff training and competence."
● The service provided care for people with a learning disability and those living with dementia. There was no training provided for staff relating to people's associated needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received regular supervision sessions. One staff member said they felt, "Well supported".
● Staff had not been receiving their annual appraisals. The registered manager contacted us after the inspection and told us that appraisals had been delayed allowing time to focus on, "More urgent paperwork".
● The service was supporting staff to complete the Care Certificate. The Care Certificate is a set of standards that all staff new to care should complete.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed, however where needs were identified there was insufficient information to guide staff how to meet these needs. For example, people who were assessed as at high risk of pressure ulcers did not have specific guidance for staff on how to maintain their skin integrity.
● People's mobility needs were assessed but not the level of support people needed to mobilise such as one

or two staff.

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

● The food looked appetising, both people and relatives spoke positively about the food. Comments from people included, "There's very good food" and one relative said, "The food is lovely". We saw people being offered a choice of meal.

● We observed one person request a drink from a member of staff, the person was not provided with a drink. During lunch time, three people chose to eat their lunch in the lounge, however the people were not provided with a drink and one relative took drinks to the three people.

● On the second day of the inspection, people were supported to the dining room an hour before food started to be served and this meant people had to wait and became unsettled. For example, one person said, "Can somebody help me" three times and was walking to the door and back to their chair and another person said, "I shall be making a complaint in the minute. Why aren't we getting any food?"

● The tables were well presented with a table cloth, condiments and serviettes.

Staff working with other agencies to provide consistent, effective, timely care

● Staff worked with external agencies, we saw a District Nurse visiting a person.

●However, one person needed dental treatment; this was identified by their local authority care assessor in February 2019, however they only received dental treatment two months later.

Supporting people to live healthier lives, access healthcare services and support

● Records showed that people were referred to their GP. People were supported to attend hospital appointments.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence

● We observed one person who was unable to transfer independently indicating that they wanted to leave the dining room after finishing their lunch. As staff supported other people to leave, they also acknowledged what the person had said with comments including, "Just relax, just rest here" and, "I'm going to get your Zimmer [walking frame] in a minute". One member of staff said they could not assist the person to move as there were no suitable chairs, when a chair was offered the member of staff declined the chair and said, "It's alright, he's got to be toileted anyway". The person had to wait 25 minutes for a staff member to bring them a wheelchair. One person said, "You don't get any help here if you don't walk or move."

● One person told staff repeatedly they wanted to return to their bedroom. However, they remained in a chair in the lounge for the day. The same person could not access a call bell as it had been moved out of their reach, staff informed us that this had happened because the person was using it as a telephone.

● Staff knocked on the doors of peoples' bedrooms before entering.

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

● We observed some kind and caring interactions between people and staff. For example, one staff member kneeled to talk with someone at eye level and was very kind and caring towards the person. One person said, I like it here, the way I get looked after."

● People and relatives spoke positively about the staff. Comments from people included, "I like the staff. They are kind, nice people" and one relative said, "Staff are kind."

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

● There was no evidence to show that people had been involved with making decisions about their care.

Inadequate

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People did not receive care that was person-centred and responsive to their needs. Peoples' care plans contained limited information about what was important to them and people had not been involved with planning their care.
- People were not supported to pursue their interests and hobbies. When one person expressed that they wished to visit shops a member of staff said, "We're a bit busy at the moment, you can't go out." No alternative arrangements were made to accommodate this person's request.
- People did not have regular access to meaningful activities. During the second day of the inspection, we did not observe people being offered the opportunity to access activities. One relative said, "The atmosphere is sad, the majority of residents just sit."
- There was no formal activities programme available at the time of the inspection. People's care records contained brief information about what activities they liked.
- There was no Activities Coordinator at the service and the registered manager told us staff were managing activities together.
- The service was working to improve the activities available to people. On the first day of the inspection a performer visited the service and sang songs. One person said, "The music is wonderful. I enjoyed every minute of it." During the inspection the deputy manager was excited as a delivery of horse shoes had arrived and there were plans to decorate these with people.
- One relative said, "My [family member] goes into town with a carer. They go for coffee and buy some things."

Improving care quality in response to complaints or concerns

- The service had received two complaints since the last inspection. The registered manager responded to both complaints in a timely manner and spoke with staff involved as required.
- Relatives told us they could approach the registered manager with complaints or concerns. Comments from relatives included, "The [registered] manager is accessible [and] listens to our concerns."

End of life care and support

- One person was receiving end of life care during our inspection. Records showed that staff were undertaking regular checks and health care professionals were involved with the person's care.
- Other people living at the service did not have any information about their preferences at their end of life.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

● The service did not consistently submit statutory notifications to the Care Quality Commission. Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. Statutory notifications are important as they help us to monitor services.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

●The provider has been required to submit the outcomes and actions relating to the audits of quality and safety since the last inspection. These had been submitted each month but had not identified the shortfalls found at this inspection and were inaccurate. The systems and processes in place were not effective.

● The action plan for improvements within the service was not complete and not all actions had a date for completion or details about who was responsible for completing the action.

● The action plan did not include information about work to be completed in the garden, although uneven ground, discarded items and gaps in security remained at the time of the inspection.

● Checks had not identified that risk assessments and care plans did not consistently provide staff with guidance about how to keep people safe and in some cases risk assessments had not been completed when necessary.

● Checks of accidents and incidents had not identified that safeguarding referrals were not being sent to the local authority safeguarding team as required.

● There was no effective system to monitor Deprivation of Liberty Safeguards and it had not been identified that two Deprivation of Liberty Safeguards authorisations had expired.

● Checks had not identified that medicines and creams were not being managed or administered safely or that necessary protocols had either not been followed or were not in place.

●There was no evidence of provider oversight of the service to check that action was being taken to improve the quality and safety of the service.

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

● We undertook an unannounced visit on 21 May 2019 as part of our inspection and to check what actions had been taken to improve safety for people. The service had removed the risk of burns from hot water. However, during our checks we identified that four people did not now have access to hot water in their en-suites.

● Medicines were still not being managed safely, this included missing protocols for 'as required medicines', recording errors and omissions and staff not having access to important information, such as a person's allergies.
● New mattresses had been ordered and delivered to the service. However, stained and malodourous mattresses remained on peoples' beds as they had not been replaced with the new mattresses.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
●The provider did not always ensure people received high-quality person-centred care. Shortfalls in people's care records had not always been identified. Care plans covered people's basic needs but did not contain information about their views and preferences.
●When incidents had occurred, the provider had not always reported these to the relevant people or included relevant information. For example, one person had been potentially assaulted, but this was not reported fully.
●Where people had been involved in incidents there was no evidence in care plans that a review had been held, relatives informed, and care records updated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager had recently sent questionnaires to staff, people and their relatives. The registered manager was in the process of reviewing the feedback from these.
● The provider or registered manager had not facilitated any recent meetings with relatives or people to seek their feedback on the service they received.
● Staff attended staff meetings in line with the provider's policy and we observed a staff meeting being held on the day of our inspection. Topics discussed included the use of personal protective equipment, for example gloves and aprons.
● The registered manager told us they had recently introduced group supervisions that were ad-hoc and occurred when the need arose.
●The culture within the service did not always promote dignity, well-being and safety. ●Environmental shortfalls in people's bedrooms did not promote respect and dignity, for example, stained and odorous mattresses and broken furniture.
●People's safety was not always promoted as steps were not always taken to keep them safe. People's care records contained generic risk assessments which did not guide staff on how to keep the individual safe. For example, how to support people who used walking frames.
●During our inspection we observed the deputy manager was visible and present throughout both days. The deputy manager was involved in care delivery and available to provide support to the staff team.
The registered manager was mostly in their office during the inspection, however staff told us they were always available and supportive.

Continuous learning and improving care
● The service had improved their recruitment process. This included reorganising staff recruitment files and the introduction of a recruitment checklist used to ensure that relevant information and background checks were available for new staff members.
● During the last inspection, we observed a curtain being used while people were being supported to use the toilet with the door open. At this inspection the curtain had been removed and people were being supported to use the toilet with the door closed. The registered manager said, "We can't drum it in to the staff enough about dignity and respect."

Working in partnership with others

- The provider had not built links with the local community.