Four Seasons (Bamford) Limited

Keresley Wood Care Centre

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

About the service
Keresley Wood Care Centre is a care home which provides nursing and personal care for up to 47 older people. At the time of our visit 28 people lived at the home. Accommodation is provided in a two-storey adapted building.

People's experience of using this service and what we found
This is the sixth consecutive inspection where the provider has failed to achieve the minimum expected rating of good.

The provider had failed to take action to meet regulatory requirements and to improve to the service people received. We found there continued to be a lack of effective governance, provider and management oversight at the home. The home did not have a registered manager and the provider had failed to ensure staff had the leadership and management support they needed to fulfil their roles effectively. Quality monitoring systems and process continued to be ineffective. This demonstrated lessons had not been learnt since our last inspection.

People and relatives told us low staffing levels and the increased use of agency staff continued to impact negatively on people's experiences. This meant people did not receive consistent good quality, safe care. The provider continued to fail to manage and mitigate risks associated with people's care. However, people told us they felt safe. The management of people's medicine had improved.

Most staff were recruited safely. Staff received an induction when they started working at the home and completed on-going training. However, the induction for agency staff was not effective and people and relatives did not have confidence in the knowledge and skills of agency staff.

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

People and relatives spoke fondly of the permanent staff who provided their care and support. Permanent staff understood the needs of the people they supported. People's privacy was respected. However, some people's dignity was compromised and their independence was not promoted. People were encouraged to maintain important relationships and had access to a health and social care professional when needed.

People's care was not always provided in line with their needs and preferences. People's care plans contained the information staff needed to provide personalised care. However, staff did not always have the time they needed to read people's care plans. The completion of supplementary records continued to require improvement to demonstrate people had received their care and support safely and as planned. People had opportunities to engage in meaningful activities. Complaints were not well-managed.

Despite our findings, people and relatives told us they were happy with the care provided but were dissatisfied with the way the home was being managed.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 May 2019) and there were three breaches of the regulations.

Following our last inspection, a condition was placed on the provider's registration for them to submit weekly reports to us to show actions taken to improve the service. We had not received all of these reports. During this inspection we found some of the weekly reports we had received contained inaccurate information regarding improvements made.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
At this inspection, enough improvement had not been made and the provider continued to be in breach of three regulations. The breaches related to risk management, staffing levels and how the service is managed.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is now 'Inadequate' and the service 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**

Keresley Wood Care Centre

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 Care Act 2014.

Inspection team
The inspection was conducted by one interim inspection manager, two 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
Keresley Wood Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post at the home. The service is required to have 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. A new manager had been offered employment and was going through the recruitment process.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from a health care professional, a social care professional and the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this

information to plan our inspection.

During the inspection
We spoke with eight people who lived at the home and seven relatives about their experiences of the care provided. We spoke with the managing director, the manager and 11 staff including, nurses, care staff, agency care staff, the maintenance person and the cook.

We reviewed a range of records about people's care and how the service was managed. This included six people's care plans, nine people's supplementary records and a range of medicine records to ensure they were reflective of people's needs. We looked at three staff personnel files in relation to recruitment, training and staff supervision and reviewed a variety of records relating to the management of the service, including quality assurance audits and checks.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient, suitably trained staff deployed to ensure people's needs were safely met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 18.

For the last five inspections the provider has continually failed to meet the required standards and achieve a rating of good in the safe domain.

• Previously, we found insufficient numbers of staff had been on duty to meet people's needs and maintain their safety. Since our last inspection, we continued to receive information of concern that informed us how low staffing levels impacted negatively on people's experiences. At this inspection the concerns remained.
• Without exception people and relatives said there were not enough staff. Comments included, "Absolutely, they are definitely short staffed," "They take a long time to come when I ask for help," and "It's not the staff's fault they are so busy, we have to wait. There just isn't enough of them."
• We saw how low staffing levels continued to impact negatively on people's experiences of living in the home. For example, one person, who was cared for in bed was feeling unwell and continually called out for staff. Whilst a staff member tried to offer the person reassurance and comfort, they had very limited time to spend with the person. Another person who was reliant on two staff to assist them to move safely, waited over 20 minutes for assistance with personal care because only one staff member was available.
• Staff told us the lack of permanent staff reduced the amount of time they had to provide care and support to people. Comments included, "We have lots of different agency and each time we have to show them what to do. That's time we should be with the residents." "Agency don't know how to do things," and, "It impacts on the regular staff. We are frustrated, with checking them, directing them…"
• People and relatives told us the use of agency staff impacted negatively on the quality of care provided. One relative described feeling concerned because their family member received support with intimate personal care from a male staff member they did not know. They said, "Imagine how she must feel." Other relatives commented, "Yesterday, they [agency staff] seemed reluctant to be helpful. It was because they didn't know [person] and weren't confident," and "It's hard. They don't know [person] well."
• The provider was heavily dependent upon agency nurses and agency care staff to cover staff vacancies and absences. Since our last inspection the use of agency staff had significantly increased. The managing

director informed us the recruitment of permanent staff was ongoing.

We found no evidence people had been harmed however, the provider had failed to ensure there were sufficient numbers of staff available to meet people's needs This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

• The manager felt confident staffing levels were 'right'. The managing director told us people's needs were regularly reviewed so staffing levels could be determined in line with the provider's requirements. They said, "Currently, staffing levels are 100% compliant with CHESS (provider's staffing tool)." However, the management team had failed to take into account the high number of agency staff who needed guidance and did not know people.
• The provider's recruitment process included completing the pre-employment checks required by the regulations, to ensure the suitability of staff working with people living at the home. However, we found the provider's procedure had not always been followed. For example, a gap in one staff members employment history had not been checked. The managing director had identified this on the day of our visit and begun to address the issue.

Assessing risk, safety monitoring and management

At our last inspection we identified people were not protected from the risk of avoidable harm because risks were not well-managed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The service has a track record of failing to manage and mitigate risks. Improvement had not been made at this inspection.
• One person had been assessed by the provider to be at very high risk of their skin becoming damaged. To reduce this risk the person slept on a specialist air-filled mattress. We checked and saw the mattress setting was incorrect because it was set for a person who weighed 80kg. The person weighted 43.2kg. Completed mattress check records showed staff had failed to identify this risk. To be effective none self-regulating mattresses need to be correctly set according to a person's weight. When we alerted the manager, the setting was corrected.
• At our last inspection the required checks of air flow mattresses had not been completed. During this visit, despite the introduction of new checks the same concerns remained. One person's records showed a gap of sixty-hours between staff completing the required checks shortly before our visit. Regular checks are essential to ensure mattresses are in full working order to prevent a person's skin becoming damaged.
• Important information about risks were not always understood by staff. One person was at risk of choking on food and they required a level five diet (moist and minced) to reduce this risk. This was recorded on the information handover sheet relied upon by agency staff to help them provide safe care. However, an agency staff member and a permanent staff member, supporting the person, did not know what a level five diet was. This created a potential significant risk to the person's health.
• The provider's fire management file was not up to date. Details for one person admitted to the home the day before our visit had not been added to the 'Person's Receiving Care List'. This meant staff and the emergency service did not have the accurate information they needed to keep people safe in the event of a fire. The administrator explained, following a person's admission they updated the list when they were next on duty because staff did not have access to the electronic form. The managing director acknowledged this poor risk management and assured us staff would be instructed to make handwritten amendments when

required.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate risk associated with people's care was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure people received their medicine as prescribed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.
• People's medicines were managed, administered and stored safely.
• Effective processes were in place for the timely ordering, supply and safe disposal of medicines.
• Medicines were administered by trained staff whose competency was regularly checked.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from the risk of abuse. Staff did not always recognise or respond appropriately to allegations of abuse. We found a safeguarding referral had not been made to the local authority when a person had sustained bruising due to unsafe moving and handling practice. Action was taken to address this on our request.
• Staff received safeguarding training and understood the different types of abuse people may experience.
• Despite our findings people felt safe. One person said, "I do feel safe here in as much as there are people around to help me."

Preventing and controlling infection
• The home was clean.
• Staff had completed infection control training and demonstrated safe working practices in relation to this.

Learning lessons when things go wrong
• Sufficient improvement had not been made since our last inspection to demonstrate compliance with regulations and improve safety. This showed lessons had not been learnt.
• Staff understood the importance of reporting and recording accidents and incidents. However, an incident involving an agency staff member which had happened the day before our visit had not been recorded. The manager took action to address this.

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

Supporting people to eat and drink enough to maintain a balanced diet
• Previously, mealtime experiences for people were not positive. During this inspection visit improvements had not been made. At lunchtime people had to wait for staff to be available to help them to eat their meals. One person had difficulty keeping their food on their fork and after several attempts pushed their plate away. There were no care staff in the dining room to help the person. The person was heard to say, "I've had enough. I'm out of here." Another person who had finished their meal asked a staff member for assistance to use the toilet. The person had to wait for over 30 minutes for assistance because staff were busy supporting other people. They person told us, "This sort of thing happens all the time."
• Some people were at risk of malnutrition and had been prescribed daily food supplements to maintain their health. However, the provider could not demonstrate these had been provided. For example, food and fluid intake records for one person indicated they had not received their supplements on 28 and 29 February 2020. Permanent staff, including the cook understood people's dietary preferences.

Staff support: induction, training, skills and experience
• People and relatives were confident permanent staff had the skills and knowledge required to meet their needs. One person said, "Our own staff are brilliant." When discussing the competencies of agency staff one person told us, "They don't know what they are doing."
• Permanent staff received an effective induction when they first started working at the home which included shadowing more experienced staff. However, inductions for agency staff did not ensure they understood people's needs and had all the information they needed to provide safe care. One relative felt agency staff were reluctant to provide people's care because they did not understand people's needs.
• Staff completed training to enable them to carry out their roles and some observations of staff practice had been completed to ensure they supported people correctly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People's needs had been assessed prior to them living at the home to determine if their needs could be met. Assessments included identifying people's preferences and life style choices.
• People had access to health professionals when needed to maintain their health and wellbeing.
• Nurses and care staff felt they had good working relationships with health and social care professionals. A health care professional confirmed they had positive working relationships with the permanent staff team.

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 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 (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met

- The provider was compliant the MCA.
- Staff worked within the principles of the Act by seeking people's consent before providing their care.
- People's care plans identified if they had capacity to make specific decisions and included details of representatives who had the legal authority to make decisions on their behalf.

Adapting service, design, decoration to meet people's needs
- The environment met the needs of the people who lived there.
- People's bedrooms were personalised with pictures and treasured items.
- People and relatives had access to a variety of communal areas.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity; Supporting people to express their views and be involved in making decisions about their care
• People did not always benefit from a caring culture. The provider had not considered the impact low staffing and high use of agency staff had on people's experiences.
• The provider was not caring and staff did not feel supported. One staff member told us, "We don't know what's happening. They [provider] don't care about us. We [staff team] have to be self-sufficient to ensure the residents are ok." Another said, "We are just left to get on with it."
• People's choices and decision making was negatively affected by staff availability.
• People and relatives spoke highly of the permanent staff and the care they provided. Those staff were described as, 'Attentive, excellent and wonderful'. One relative said, "The staff are very kind to my mom."
• Permanent and some agency staff demonstrated a caring attitude but they were unable to provide timely personalised care because they were busy. This made staff task focused. However, we saw some exceptional examples of kindness being shown to people by permanent staff. One staff member despite trying to administer people's medicines, direct agency staff and arrange medical appointments, made time to comfort a person who was distressed.
• Staff had completed equality and diversity training and understood the importance of respecting people's differences and preferences. However, one relative told us their family member's preference for personal care to be provided by female staff, was not always met. The relative told us they found this concerning.

Respecting and promoting people's privacy, dignity and independence
• Language used by some staff was not respectful. We heard one staff member say to a person, "You've been a good girl and eaten your dinner." Another staff member entered the dining room, nodded towards a person and said to their colleague, "Has she had her pudding?"
• Some staff did not promote people's independence. One staff member placed a wheelchair in front of a person and said, "Are you ready?" The staff member looked shocked when the person got up and walked out of the room.
• Overall, people's privacy was respected but some people's dignity was compromised due to the length of time they had to wait for staff to help them use the toilet.
• People were supported to maintain relationships with people that mattered to them and family and friends visited their family members when they chose.
• People's confidential information was securely stored in line with legislative requirements.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

For the last three inspections, the provider has failed to achieve a rating of good in this domain.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People did not always receive responsive care. Low staffing levels identified at our previous inspection and detailed within this report, meant staff were not available or did not have the time they needed to provide individualised care. One relative said, "The carers are excellent but over the last two weeks it has been hard, [names] teeth haven't been cleaned and her nails have been quite dirty, I cleaned them for her in the end."
• Staff were not always responsive to people's requests. When one person asked for help to go to the toilet a staff member responded by saying, "Could you wait, so we can finish helping the other residents we are looking after."
• Staff were not always available to meet people's preferences, for example the gender of staff who provided personal care.
• Previously, people's daily care records had not been fully and accurately completed. Following that inspection, we received assurance additional checks had been put in place to improve this. However, during this inspection we found the same concerns. One person's records documented they had been assisted by staff to clean their teeth. This conflicted with our observations because we saw the person's toothbrush was dry. Fluid intake, urine output and catheter care records for another person contained significant gaps and omissions. Poor record keeping indicated people were not receiving their care as planned.
• Overall, people's care plans were up to date and provided staff with the information they needed to provide personalised care. However, staff did not always have time to read care plans. One told us, "If, on the rare occasion you get a minute you can."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People enjoyed the varied range of activities provided.
• People were supported to practice their religious beliefs. We saw people who chose to attend a religious service sung hymns and prayed together.

Improving care quality in response to complaints or concerns
• Relatives were not confident their complaints were listened to and addressed. Comments included, "It is like banging your head against a wall (to complain),"and, "You're told to complain to the manager but I don't think there is one."
• The provider had failed to ensure complaints received were managed in line with their procedure. Records indicated two complaints made by relatives had not been fully investigated and responded to. The manager assured us this would be address.

Meeting People's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People had access to some information in different formats including, pictorial and large print.
• People's communication needs had been assessed. Permanent staff used people's preferred methods of communication to ensure communication was effective.

End of life care and support
• People's end of life wishes were documented if they had chosen to share this information.
• Staff worked in partnership with healthcare professionals to ensure people had a comfortable and pain free death.

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 this key question was rated as requires improvement. At this inspection the rating has deteriorated 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.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

Since 2015 the provider has either failed to make improvements to the service people received or had failed to comply with regulations. At our last inspection the provider had not implemented effective governance systems. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider remains in breach of regulation 17.

For the last six inspections the provider has continually failed to meet the required standards and achieve a rating of good in the well-led domain.

• Keresley Wood Care Centre has been inspected on six occasions since January 2015. The overall rating has either been requires improvement or inadequate.
• The provider's continued lack of oversight meant they had failed to take action to demonstrate compliance with regulations and make the necessary improvements to benefit people.. This placed people at risk of harm and demonstrated lessons had not been learnt.
• The provider's systems to monitor the quality and safety of the service remained ineffective. For example, checks of medicine and care records did not clearly detail why the need for improvement had been identified, or if actions had been taken to improve outcomes for people.
• Despite continued feedback from people, relatives and some staff the method used by the provider to determine staffing levels did not ensure people's needs were met.
• Following our last inspection, a condition was placed on the provider's registration. This required them to provide us with a weekly action plan report detailing the monitoring checks completed and improvements made. We had not received all of the required reports. The managing director told us this was because they thought the requirement was for a monthly submission. Monthly action plans had been submitted in February and March 2020.
• During this inspection we found improvement action plans that had been submitted to us contained

inaccurate information. For example, the last plan we had received informed us people's supplementary records were being completed. Our inspection findings confirmed this was incorrect.
• Information available on the provider's website and displayed within the home, was misleading because it informed people, relatives and the wider public the previous registered manager was still employed at the home. This was addressed by the managing director when we brought it to their attention.

• Partnership working was not always effective. Instability within the management team had resulted in information not being shared in a timely manner. A health care professional told us they had been waiting for over two months for the management team important information from the management team. They said, "Each time I ring it's a different manager and no one knows where the investigation report is." We shared this feedback with the managing director who took immediate action to locate and forward the information.
• Poor communication negatively impacted on people, relatives and staff. Without exception people, relatives and staff told us the provider had not informed them about changes happening at the home. One person said, "People are telling me this place is going down and I might not be here soon, that worries me. No one tells me anything." A relative said, "I have no idea what is happening. Is there a manager. Who is the manager?"
• The home did not have a registered manager as required by the regulations. Since the service registered with us in 2011 five different managers had been employed and at the time of this inspection recruitment of a permanent manager was ongoing. An interim manager had been appointed who told us they had been working at the home for four days.
• The provider had failed to ensure staff had the management support and leadership they needed to fulfil their roles effectively.

We found no evidence that people had been harmed. However, service oversight was ineffective. Systems and processes were not established and operated correctly. There was a failure to make and sustain improvements to benefit people. This was in continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had met the legal requirements to display the services latest CQC ratings in the home and on their website.
• The manager understood their regulatory responsibility to inform us about significant events that happened at the home.
• People and relatives were able to provide feedback about the service they received. However, the actions taken in response to feedback was not always accurate. For example, people and relatives had been informed a list of 'resident and relatives' meetings was displayed in response to requests for opportunities to participate in meetings about how their home was run. We checked an found this information was not displayed. The managing directed confirmed this.
• The managing director informed us due to concerns about inconsistent leadership and management at the home the local authority had taken the decision not to admit people into the home until improvements were made.
• The home had achieved accreditation to a pressure ulcer prevention scheme awarded by health and social care partners.

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
• The manager understood their responsibility to be open and honest when things had gone wrong.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) HSCA RA Regulations 2014. Safe care and treatment The provider had not ensured care and treatment was provided in a safe way. The provider did not protect people against risks by doing all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured the effective monitoring and mitigation of risk timely action was taken and risk reduction measures introduced to minimise known risk. The provider had not ensured records relating to the care and treatment of each person using the service were completed, accurate and up to date. The provider had not ensured required improvements to the service provided had been

made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) HSCA RA Regulations 2014. Staffing The provider had not ensured sufficient numbers of staff were available to meet people's need.