# Care Worldwide (Bradford) Limited

# Owlett Hall

## 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: Owlett Hall is a residential care home providing personal and nursing care to 53 people aged 65 and over at the time of the inspection.

Why we inspected: This inspection was prompted by concerns we received. At the time of the inspection we were aware of incidents being investigated by the local safeguarding team.

People's experience of using this service: People were not always safe and did not receive support when they needed it. There were not enough staff to meet people's needs. Staff were not able to respond to people's call bells promptly. Risks to individuals were not assessed and appropriately managed which placed people at risk of harm. Some people did not receive their medicines as prescribed. Lessons were not learned when things went wrong. Systems in place to ensure safeguarding incidents were reported appropriately were not robust.

People's nutritional needs were not always met and the dining experience was not positive for people. Staff contacted health professionals when required, however this was not always timely. Staff did not always receive an induction, or complete appropriate training to ensure they had the skills they required for their roles. Staff did not consistently receive supervision and appraisal of their performance. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Some caring and kind interactions were observed during the inspection. However, some people told us they did not feel comfortable with staff. People had care plans regarding their support needs. These care plans lacked important information and were not always kept up to date when changes occurred. There was limited guidance for staff on how to deliver care in a person-centred way. The provider had a procedure for investigating complaints, but this was not always followed in practice.

The service was not well-led. The governance of the service was poor and the provider's quality management systems were not effective. They had not identified areas where the service needed to improve.

After the inspection, we requested an urgent action plan from the provider to tell us how they would address the concerns we found. They responded with a plan which gave timescales for the completion of work to improve the service.

We identified seven breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of the CQC (Registration) regulations 2009.

Details of the action we have asked the provider to take can be found at the end of this report.

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

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published 15 January 2019).

Enforcement: Please see the 'Action we have told the provider to take' section at the back of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority, clinical commissioning group and safeguarding team.

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, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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**

# Owlett Hall

**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.

Inspection team: On the first day of the inspection, two inspectors were present. On the second day an inspector and assistant inspector were present. On the third day two inspectors and an assistant inspector were present.

Service and service type: Owlett Hall 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.

It is a condition of the provider's registration that they have a manager registered with CQC. At the time of the inspection, a manager was registered with the Care Quality Commission. However, they were no longer in post. An interim manager had been appointed at the time of our inspection. Within this report they will be referred to as the manager.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection, we liaised with the local authority and the safeguarding team. We did not ask the service to complete a Provider Information Return before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the information we held about the service including notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted local Healthwatch England. Healthwatch England is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with the manager, five regional support managers, two regional directors, the clinical director, an activities co-ordinator, a maintenance person, the administrator, one nurse, one agency nurse, eight care staff and two agency care staff. We also spoke with eight people who used the service and two relatives. We spent time observing the environment and the dining experience. We spoke with one visiting healthcare professional.

We looked in detail at six people's care records and five people's medication administration records and a selection of documentation about the management and running of the service. This included recruitment information, staff training records, audits, policies and procedures and staff rotas.

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.

At our last inspection in November 2018, we found areas of the service were not always safe. We found the deployment of staff needed to be improved to ensure people's needs could be consistently met. We found shortfalls in the records relating to medicines. At this inspection, we found improvements had not been made and these risks remained or had increased.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
•Some people told us they felt safe living at the service. However, two people told us staff were either careless or had a poor attitude and this made them anxious.
•We found evidence of poor care that had put people at risk. Daily records noted one person had been shouting out and staff had closed their door because of this. We found a member of staff asleep in the room of a person they were supporting on a one to one basis. The manager took action during the inspection in response to the concerns we raised.
•Prior to our inspection we received a range of concerns about the service. We looked at these issues throughout the inspection. We also liaised with the safeguarding team and the local authority about their on-going investigation of these concerns and allegations of neglect.
• The provider had not always ensured they reported safeguarding incidents to the local authority. Safeguarding records did not clearly show if investigations had taken place or if action had been taken to prevent re-occurrence of incidents. Staff said they did not get feedback on concerns or complaints raised about the service.

The failure to ensure people were protected from abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Accidents and incidents were logged but there was no analysis carried out. We were therefore unable to evidence any learning from incidents took place.
•Most staff had completed safeguarding training. Those we spoke with could describe how to protect people from the risk of harm.

Using medicines safely; Assessing risk, safety monitoring and management; Preventing and controlling infection.
Medicines were not managed safely, and people did not always receive their medicines as prescribed. There was no information available to guide staff on when medicines that were prescribed to be taken 'when required' should be given. It was not possible to say if creams were being applied as prescribed as records relating to topical medicines were poor.
•Medicines were not always stored securely. Fridge and room temperature checks were not carried out

consistently to show medicines were kept at appropriate temperatures. When eye drops were opened the dates were not recorded to ensure they were discarded within the required time range.
•Two people received covert medicines (medicines given without their knowledge). A pharmacist had not been consulted on the best way to administer these medicines to ensure their effectiveness.
•Risks to people were not appropriately assessed and managed. Risk assessment's in people's records did not reflect people's current needs. Where risks had been assessed appropriate plans had not been implemented to reduce these risks. Staff did not ensure equipment to improve safety was consistently in place such as call bells and safety mats.
•There were some concerns about moving and handling practices. We saw a person supported in an inappropriate manner. A visiting health professional reported they had seen a member of staff use an unsafe moving and handling technique.
•The provider had failed to identify and manage risks within the service. Sluice and maintenance room doors had been left unlocked. These rooms had machinery or substances in them that could cause harm.
•A fire risk assessment had been carried out. Areas of risk that had been identified had not been documented as completed.
•The premises and environment of the service were not always clean. Staff demonstrated some poor hygiene practice. This included when handling medicines and disposing of soiled items or clinical waste.

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

• There were suitable arrangements in place to manage medicines which required extra security.
•Some checks had been carried out by staff and external contractors to make sure other aspects of the premises and equipment were safe and clean.

Staffing and recruitment.
•The provider had not calculated staffing levels in line with people's needs which resulted in poor standards of care for some people. The manager confirmed the home's dependency tool could not be relied upon to identify the number of staff required.
•There was consistent feedback from people, staff and relatives that there were not enough staff. Our observations showed there were not enough staff on duty which impacted on people's care and support. People had to wait for support to use the toilet which left them feeling distressed and anxious. Staff said there were not always enough staff to supervise people safely and make sure people received person centred care.
•Staffing levels were supplemented by the frequent use of agency staff who had not always had an induction to the service and told us they did not know what people's needs were. Agency staff were not regular or consistent.

The lack of sufficient staff meant people were not always safe. This demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The manager increased the number of staff on duty, both through the day and night, during our inspection. This was in response to concerns we raised. We saw this made some improvement to people's experience and the standard of care provided.
•Overall, staff recruitment records showed robust procedures were in place. One member of staff's records did not show a full employment history had been obtained.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Some regulations were not met.

Staff support: induction, training, skills and experience.
•Staff were not always suitably inducted, trained or supported to perform their job roles. A nurse who had been in post for several weeks had not had an induction. Agency staff also told us they did not receive an induction to the home.
•Two relatives raised concerns about some staff's understanding of their family member's needs.
•Training records showed many staff had not completed up to date training in a range of training subjects. Some staff had been in post for over a year and had not completed all the required training.
•Records were not always available to show staff had received supervision and an appraisal of their work performance. It was not clear how staff's performance was checked to make sure they were competent.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not effectively supported to undertake training, learning and development to enable them to fulfil the requirements of their role.

•The manager had developed a new training plan to ensure staff training was completed or updated.

Supporting people to eat and drink enough to maintain a balanced diet.
•One person told us they were hungry and had not had their breakfast; it was late morning. Another person told us they were thirsty. We saw they had a dry mouth and drank a cup of tea in one go when this was provided.
•The lunch time meal experience was not always well organised. Some people, who received their meals in their rooms, waited up to two hours after the start of the meal to receive their dessert. When this was served it was a milk pudding that had gone cold or ice-cream that was melted almost to liquid.
•There were no menus available in the dining room. One person did not want the meal on offer and was not offered an alternative; they were told there was only a dessert available to them. A person in their room was left with a plate of food in front of them for two and a half hours. They did not receive any support to eat their meal.
•People had care plans and risk assessments in place to identify their nutritional support needs. These were inconsistent or ineffective and were not always followed by staff. A relative told us they were concerned at the weight loss of their family member. They said, "We've asked for a nutritionist to come but they've not followed it up." We raised this with the manager and a referral was made.

The failure to ensure people had adequate nutrition and hydration demonstrated a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

•Some people told us they enjoyed the food and their weight was monitored. One person told us how much they enjoyed the breakfasts and the choice available. Another person said there was always alternatives if they didn't like what was on the menu.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.
•People had access to health professionals to meet their health care needs. However, advice from healthcare professionals was not always sought when people required it. For example, a person's consultant appointment had been overlooked.
•A visiting health professional told us the service was not always prompt enough in making referrals in response to people's health needs such as weight loss and increased falls.
•Where health care professionals had recommended specialist equipment for people, the provider had failed to ensure this was obtained in a timely manner.
•Most staff told us good systems were in place to make sure people's health needs were met. One member of staff raised concerns that agency nurses did not always know people well enough to be able to recognise if a person was not their usual self and unwell.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•Care and support delivered did not always meet best practice guidance. Poor moving and handling practice put staff and people who used the service at risk of injury.
•People's needs were assessed before they moved into the service to make sure the service was suitable for them.

Adapting service, design, decoration to meet people's needs.
•The premises were dated and tired looking. People had their own en-suite bedrooms. Some were homely and spacious. However, some rooms lacked stimulation and bedding was creased and shabby looking.
•There was outside space for people to enjoy in the better weather. At the time of the inspection, repairs were required to fencing to ensure the security of the garden. This work had been ordered.

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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•Records showed people's capacity to consent to various aspect of care or treatment had been assessed. Where a person lacked capacity to make a decision, a best interest decision had been made with family members and other professionals, such as social workers or GPs.
•Staff supported people in the least restrictive way possible; policies and systems in place supported this

practice. Appropriate applications for DoLS had been made to the supervisory body when necessary.

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.

Ensuring people are well treated and supported; respecting equality and diversity.
•People said they were not always treated with compassion and kindness. One person said they did not always find staff to be kind and caring. They said, "Some staff are not kind; it makes me cry. Some are better than others though." However, another person said, "They're all lovely. They are miracle workers."
•There were times when people were calling out for assistance as they did not have their call bells in reach. One person who did not have a call bell said, "The girls are good but it's the time factor; often have to wait. Not enough staff." A replacement call bell was found for them during the inspection.
•Two relatives had concerns that their family members were not always wearing their own clothes. We saw some people were unkempt and were wearing stained clothes.
•A person whose first language was not English had a communication care plan which stated they needed the support of a person who spoke their language to enable them to express their preferences and any unhappiness. No-one in the service spoke their language and no interpreter service had been accessed.
•The provider had failed to ensure all staff had completed training on equality and diversity.
•Care plans had sections to record people's preferences such as their preferred name and gender of staff they wanted to support them.
•Some caring and kind interactions were observed during the inspection. It was clear some staff had developed good relationships with people. A relative, when speaking about staff, said, "They always seem genuine." Another relative said, "There's more staff now and it feels nicer." A person who used the service said, "Its lovely here."

Supporting people to express their views and be involved in making decisions about their care.
•People had opportunities to make choices. We saw people were asked what they would like to eat or drink and where they would like to spend their time. Staff provided examples of how people were given choice and encouraged to make decisions.
•Some staff were task focused in their interactions and communication with people and did not always have time to engage in meaningful ways with people.
•People's families said they felt involved in their family member's care. They also said they felt welcome at the service. People had signed consent to their care and support; although for one person this had not been reviewed for some time.

Respecting and promoting people's privacy, dignity and independence.
•People were not always treated with dignity as there were not enough staff. Staff were not always able to respond in a timely way when people needed support. One person said, "It is not alright when you can't get to the toilet and are desperate for the loo."
•Most staff showed a good awareness of privacy and understanding of people's needs. However, agency

staff told us they had difficulties in getting to know people's needs and preferences as they were not always fully informed. One agency staff member said, "They just tell you to go and 'do this person'. They don't tell you if a person can walk; or there is nothing being said about the life of the person. I only get to know them by myself."

•We saw staff respected people's privacy. For example, staff knocked on people's doors and waited to be asked in before entering.

•Staff were aware of the importance of supporting people to be as independent as possible. However, we saw one person was not supported to maintain their independence when eating. A staff member took over the support and this caused the person some anxiety.

Requires Improvement

# Is the service responsive?

## Our findings

People's needs were not always met. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support.

•People's care and support needs were not fully identified and recorded in care plans. They did not include information about people's up to date care needs, or information about their preferences. Some people's records were inconsistent and provided conflicting information. This meant care plans did not provide staff with clear guidance on people's support needs.
•Daily recordings on the care and support people had received were not always fully completed. This included records of re-positioning people to maintain their skin integrity. Staff told us they did not always have time to complete them.
•Care plans were not updated in response to significant changes in people's needs. Care plan evaluations did not identify whether planned care had been effective, or if it was meeting the person's needs.
•Care plan reviews did not take place at the time intervals stated by the provider. A person who had lived at the service for over a year had not had a review since their admission. The care records indicated these should have taken place after three and six months. We saw this person was at high risk of falls and had experienced several falls.
•Some agency staff were not aware of people's needs. One said, "My first day, I was put with [Name of person] and I wasn't told anything about them."
•Care plans did not show how the provider was meeting people's communication needs or meeting the requirements of the Accessible Information Standard (AIS). From August 2016 onwards, all organisations that provide adult social care are legally required to follow the AIS. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers.
•Activities arranged were limited and did not meet the needs of people using the service. One person said," I have no one to talk to. There is nothing to do. I stay in bed all day." A relative told us their family member would enjoy some exercise but there were no opportunities for this.
•We looked at the 'Social and spiritual care plan' for a person. The care plan did not include details about person's interests, likes and dislikes. The person told us they were fed up and felt in need of some fresh air. Their care plan showed they were at risk from low mood and should be offered individual activity to address this. Records did not show they had been supported in this way.
•An activities timetable was displayed in the service. This was not accessible to everyone in the service. It was unclear how people got to know what activity was on and when. Staff said they had little time for socialising with people or supporting them with activities of their choice.

The lack of assessing and planning care and support meant people's needs were not fully identified and met. This demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Some staff could describe the person-centred care people required. This included how people liked to be supported and communicated with.
•The manager had recruited a second activities organiser to improve the activities on offer to people. They had started to get to know people and were in the process of finding out people's interests. They said, "One lady upstairs loves reading so I've managed to find her some books that she likes. She's over the moon with that. It's made her day better."
•There were some activities that took place during the inspection. This included games of dominoes and a group activity of giant snakes and ladders. One person went for a walk outside after we informed staff of their wish to do this.
•People's care plans showed discussions were held about their wishes on end of life care. The service had recently received a compliment from a relative on the standard of end of life care provided by the staff.

Improving care quality in response to complaints or concerns.
•Some people were not confident the provider would respond to their concerns and complaints. A relative said they had been told in the past they would not be able to visit the home if they complained. They also said they did not see anything change in response to concerns raised. They reported being spoken to in an offensive manner when raising concerns.
•Records of complaints were poor and we could not be certain complaints were managed effectively. The complaints file showed two complaints had been recorded. However, we were aware of others that had been raised with the provider and these were not recorded.
•Complaints records did not indicate how they had been investigated or what actions had been taken to address the concerns raised. The provider had not used complaints to monitor trends over time so that improvements could be made. For example, there was a complaint made in February 2019 about a person not receiving their creams as prescribed. We found there were still concerns about creams not being administered as prescribed.

A failure to respond to complaints and make improvements demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider had a complaints process in place and people were aware of how to raise their concerns.

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.

At the last inspection this key question was rated as Requires improvement. We found a lack of completed and accurate records to show when care had been given. Medicines administration records were not always completed, nutritional charts to document people's food intake had not always been recorded and some audits were not effective in identifying issues. At this inspection, we found improvements had not been made and these risks remained or had increased.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

•The service was not well led. The registered manager had recently left the service. A new management team were in place. However; they were not yet familiar with the service and the needs of the people living there.

•The senior management team and provider did not have overview of the service. Records known as key performance indicators had been completed and submitted to the senior management team. There was no evidence of action taken in response to shortfalls identified such as gaps in training and complaints.

•Quality management systems were not effective. Systems had not been effective in identifying shortfalls and unsafe practices. As a result, standards had declined since our last inspection.

•People had not been protected from unsafe staffing levels as the provider had not completed an accurate and up to date assessment of people's dependency.

•The provider had not ensured staff were fully trained and supported to provide safe, effective and responsive care.

•There was a lack of monitoring systems relating to people's weight loss. This meant there had not always been a timely response to protect people from these risks.

•People were at risk because accurate records were not consistently maintained. There were gaps in people's medicines records, repositioning and personal care records. We could not be assured that people's care needs were being fully met.

•Accident and incidents were recorded monthly. However, trends and patterns were not identified, and records did not show what was in place to prevent re-occurrence. Safeguarding records did not include information about how safeguarding concerns had been investigated and actions taken to address the issues raised.

•People's complaints were not always actively listened to and were not always responded to appropriately. They were not used to drive improvements within the service.

•Handover and communication systems were ineffective and important information was not always being effectively shared, especially for agency staff. This meant people were at risk of harm and had resulted in

poor standards of care being delivered.

The shortfalls in governance and failure to implement improvements demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Most notifications had been sent to the CQC. However, we found seven incidents across a one-month period, relating to safeguarding which had not been reported via a statutory notification in line with legal requirements. Statutory notifications contain information about changes, events or incidents that the registered provider is legally required to send us so that we can monitor services. This failure to notify is a breach of regulation 18 of the CQC (Registration) regulation 2009. We are dealing with this outside of the inspection process and will publish a supplementary report once we know the action we will be taking.
•Overall, staff expressed confidence in the new manager and management team. One member of staff said, "Yes, I feel like I can speak to the managers; any one of them." Staff said the home was better organised with the new management arrangements in place.
•People who use the service and their relatives said they had noticed the positive difference the new management team were making. One relative said, "I feel the new managers have taken action. They listen and are approachable. I'm confident things will change."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.
•People who used the service and their relatives had some opportunities to share their views and put forward ideas although these were not always acted upon. A relative told us, "I think we had a meeting last year, but I didn't go. It's a waste of time." They also told us they had not been kept informed of the current management arrangements at the service.
•The manager had arranged to meet with some people and their relatives. A relative said, "We've just been seeing the trouble-shooter lady [manager]. Someone booked us in for a meeting with her. She seemed to understand our concerns."
•Staff were not kept informed of important issues that affected the service. However, recent meetings had taken place and there were plans in place to increase these to ensure this aspect of communication in the service was improved.
•The management team were working with the local safeguarding authority to drive improvements and learn from incidents.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The lack of assessing and planning care and support meant people's needs were not fully identified and met. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure risks to people's health and wellbeing were managed safely.<br><br>Medicines were not always managed in line with best practice.<br><br>The lack of identifying, assessing and managing risk meant people were not always safe. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure people were protected from abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider had failed to ensure people had adequate nutrition and hydration. |

Treatment of disease, disorder or injury

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had failed to respond to complaints and take action where necessary. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure robust governance systems were in place at the service.<br><br>Records were not always up to date, and did not contain guidance for staff to follow about people's current care needs.<br><br>Records which related to the management of the service were not well managed. |

| Regulated activity | Regulation |
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| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The lack of sufficient, competent staff meant people were not safe.<br><br>The lack of support meant staff were not enabled to carry out their role competently. |