Harpers Villas Care Centre Ltd

Harpers Villas 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
Harpers Villas Care Centre is a care home providing personal care to 26 people aged 65 and over. At the time of the inspection 17 people lived at the service. People who used the service had a range of support needs related to old age and dementia. The accommodation is organised into three floors, however the top floor was not in use at the time of the inspection.

People's experience of using this service and what we found
People were not sufficiently protected from the risk of harm, including potential abuse, risks associated to health conditions and the behaviour of others. People did not always receive their medicines as prescribed. People told us there were not enough staff to meet their needs and our observations confirmed this.

The management of the service was inadequate as the provider did not carry out robust checks to ensure that care was being delivered safely and effectively. Audits were carried out by the management team and provider, but they had failed to ensure that people were always safe and their needs were being met. As a result, people were exposed to the risk of harm.

We received mixed feedback from people in respect of meals. Meal times were functional rather than a pleasant social experience. Guidance from healthcare professionals were not always followed to ensure people's needs were met. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People did not receive support that was consistently caring and respectful. Care given was task centred rather than person-centred and not all needs were met.

People had limited opportunities to be involved in meaningful activities. People and relatives felt able to make a complaint but did not always receive a satisfactory response. People's personal wishes during their final days had not been fully explored.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 30 October 2018) and we identified a breach of regulation 17, good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had not been made and the provider was still in breach of regulation 17 and further breaches were also identified. The overall rating of the service has deteriorated to Inadequate.

Why we inspected

The inspection was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. The information CQC received about the incident indicated concerns about the management of falls. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe section of this full report.

Enforcement:
At this inspection we have identified breaches in relation to safe care and treatment, safeguarding, good governance and staffing. The inspection also identified breaches in relation to the provider's failure to notify the commission when Deprivation of Liberty Safeguards (DoLS) were authorised as is required. 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: Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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**

Harpers Villas 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 team consisted of an inspector, an inspection manager, an assistant inspector 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
Harpers Villas 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. The service did not have a manager registered with the Care Quality Commission. There was an 'office manager' in place who was managing the day to day running of the service.

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. This includes information about specific events and incidents that the provider is required to notify us of by law. We sought feedback from the Local Authority and professionals who work with this service. We reviewed information about the service from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with ten members of staff including the provider, office manager, deputy manager, care workers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data 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. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not protected from the risks associated with skin damage. One person had skin damage and a health care professional advised for the area to be elevated. The care plan had not been updated and some staff were not aware of this requirement. Our observations on inspection were this was not being completed and there were no records to evidence this. This meant the person was at risk of further skin deterioration.
- People were not protected from the risks associated with malnutrition. We found some people were not receiving their supplements as prescribed and nutritional risk assessments were not always in place to guide staff how to reduce the risks of malnutrition. Kitchen staff were not aware of who was at risk of weight loss and their records were not up to date. For one person the dietitian had recommended high calorie and protein meals and drinks but there was no evidence this was being provided. This placed the person at risk of further weight loss.
- Where people had demonstrated 'distressed behaviour', care plans and risk assessments were not always in place. Where they were in place they did not contain sufficient guidance. Staff we spoke to were not always aware of potential 'triggers' for behaviour, and there was no evaluation of the behaviour to learn lessons and further support people.
- People were not protected from the risks of poor moving and handling practices. Equipment for one person had continued to be used despite a health care professional advising it was unsafe. This had resulted in the person sustaining an injury.
- Risks were not always adequately assessed and mitigated to protect people from falling. One person was at risk of falling out of bed and rails had been put in place to prevent this. The person had become stuck between the rails and sustained an injury. There had been no consultation with relevant health care professionals and incorrect equipment had been used.
- Follow up action was not consistently taken following accidents and incidents. For example, one person had experienced an incident of choking. There was no risk assessment in place to mitigate this risk and some staff we spoke to were not aware of the incident. This meant the person had not been sufficiently protected from harm which increased the risk of a further incident.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

- The provider maintained the safety of the building and equipment through regular checks, servicing and maintenance. Fire safety checks were completed. Personal evacuation plans were in place but were not personalised.

Using medicines safely

● We found medicines management systems were not always safe. People were not always administered their medicines as prescribed and monitoring systems were not robust.

● On the day of inspection, we found one person had been without two of their prescribed medicines for fifteen days. This hadn't been identified by the staff and there was no consultation with the GP or pharmacist on what the impact would be for the person. We were advised this was due to an error with ordering the medicines and they had now been ordered.

● For some people who required medicines to be administered as and when required (PRN), there were no protocols in place for staff to follow. This included a medicine for pain relief and medicine prescribed to reduce distressed behaviour. We found the people concerned would not be able to make a decision about when they needed this medicine.

● On the day of the inspection visit, we observed a staff member had not ensured a person had taken all of their medicines. We saw part of the medicine remained in the bottom of the beaker they were given.

● We reviewed the Medicine Administration Records (MAR) for people who were having prescribed topical creams applied to their body. We found records of where the creams were being applied were not in place and gaps in the MAR records showed that people were not receiving the treatment as prescribed.

We spoke with the deputy manager who advised they had plans to improve the medicines systems by implementing PRN protocols and improve the recording of creams.

The providers failure to ensure medicines management systems were safe was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Staffing and recruitment

● Most people and relatives we spoke with told us there were not always enough care staff to support people. One person told us, "The staff are nice but there isn't enough of them, if there isn't someone in here [lounge] you have to wait for them to catch their attention," and a relative said, "There isn't enough staff, sometimes there isn't anyone in the lounge."

● Staff told us they needed more staff in order to meet people's needs. One staff member said, "Staffing levels are too low to provide the care that service users need." Other staff members told us due to people's needs they didn't have time to spend with people and staff were rushed.

● On the first day of our inspection an extra member of staff had come in to complete audits. We observed they were called on throughout the day to stay with people in the lounge and spent time supporting someone who was disorientated and at risk of falling. If this member of staff had not been present people would have been at increased risk.

● Throughout the inspection there were periods of time when the lounge did not have a staff presence. We saw one person's care plan said all communal areas should be staffed when they were present to reduce the risk to other people, we saw that at times this was not followed. There had been an incident when a person alleged this person demonstrated distressed behaviour which had caused them harm and no staff had been present.

● We saw one person's records noted the person did not have breakfast due to the high demand on staff. For another person a relative had raised a complaint as there were not enough staff to give them a bath.

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

Systems and processes to safeguard people from the risk of abuse

● People were not consistently protected from abuse. There were multiple safeguarding concerns being investigated by the local authority at the time of our inspection.

● One person had made an allegation of abuse. The service had not taken any action in relation to this and failed to identify this as a safeguarding concern. Safeguarding procedures were not followed by the provider and the concern was not reported to or investigated by the relevant body.
● The provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made. On inspection we identified three current safeguarding issues which were referred to the local authority. These had not been identified by the provider.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

● Care staff we spoke to were able to explain what abuse was and the actions they would take where people were at risk of harm.

Preventing and controlling infection
● We observed the home was clean and staff wore aprons and gloves when appropriate to reduce the risk of infection. One person told us, "My room is perfectly cleaned every day."
● Staff had received training on infection control and prevention.

Learning lessons when things go wrong
● Accidents and incidents were recorded however, there was limited evidence of lessons learned. For example, in relation to falls, or people being found on the floor. Immediate action was taken but no analysis of the information or lessons learned highlighted.

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 now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff told us they received training and the management showed us the training matrix. This showed most basic training was completed but this was not consistent and there were some gaps.
- We saw staff had completed training in 'dementia' and 'behaviours that may challenge', however some staff could not recall this training or the learning from it. We found staff did not always have the skills or time to work effectively with people living with dementia. This meant that people were at risk of being supported by staff who may find it difficult to understand people's specific care needs.
- We found while some competency checks and observations of staff were completed by the manager these were not effective. They failed to identify the concerns we found during our inspection and did not result in action being taken to drive improvement.
- Care staff we spoke with told us they felt supported in their roles and received regular supervision.

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

- People and relatives gave us mixed views about the food. One person said, "The food is very nice there are two choices, yes I think I could ask for something else." Some relatives told us the standard had deteriorated recently due to the main cook being off work.
- We found mealtimes were not a positive experience for people. There were no condiments or napkins on the tables . People were not offered a choice of drinks and they was minimal conversation. One person who needed support to move, was left on their own after finishing their meal for a considerable amount of time.
- The cook did not have knowledge of people at risk of weight loss and the dietary records of people were out of date. This meant no fortified food was provided where assessed as required to encourage weight gain.

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

- Two health care professionals we spoke to raised concerns about the service. One told us, "There is poor communication from the top," and another raised concerns about negligence of the person they had come to see. These concerns had been raised with the local authority safeguarding team and were in the progress of being investigated.
- Health care professionals' advice was not always followed. This meant people were at risk of their condition deteriorating. For example, in relation to pressure area care and concerns about weight loss.
- There was not always appropriate guidance in place of when to refer to health care professionals. For one person it said the dietician may need to be referred to but didn't give guidance when this needed to happen.

For this person we saw there had been a delay in making the referral when the person had lost weight.
● People told us they had access to the doctor if required. One person said, "If I need to see the doctor he comes in."

Adapting service, design, decoration to meet people's needs
● We saw most people used the main lounge, which did not have any windows. One person told us, "It's nice but there is no air or windows. Sitting in here is terrible you just sit staring around." There was a conservatory area which was light and had doors opening onto the garden, but this appeared to be used mainly for visitors and we did not see people being offered a choice of where they wanted to sit. The management told us they were arranging door guards so access to this room was made easier.
● Some consideration had been made to adapt the environment for people living with dementia, including signage on doors and an activity board in the corridor. A board to show the date, weather and season was in place in the dining room but was significantly out of date, which could cause people to be more confused and disorientated.

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 when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● We found DOLS applications had been submitted to the local authority as required by law to deprive people of their liberty in order to protect their health and wellbeing.
● Staff told us they had received training in the MCA and DoLs and this was confirmed by the training matrix. Not all staff demonstrated an understanding of the MCA and DoLs.
● For some key decisions there were no MCA assessments or best interest decisions in place for people who lacked capacity. Some care records showed evidence when there was a Lasting Power of Attorney in place, but this was not consistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw assessments were being completed prior to a person moving into the service for the first time. However, we found these assessments were not always adequate in identifying people's needs.
● We saw care plans did not contain personalised information about how people liked their care to be delivered. Staff did demonstrate some basic knowledge of people's choices, but this was limited and not adequate to ensure people's needs and choices were met.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant 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

- Most people and relatives told us staff were kind and caring. One person said, "Staff are so kind," and a relative told us, "They staff are ok, seem kind enough, you don't hear any raised voices."
- We observed periods of the day where staff did not take time to talk or interact with people. For example, we saw very little conversation at mealtimes. Staff sometimes missed opportunities to engage with people as they were focused on getting jobs done. One person told us, "The staff are kind to me but they don't really talk much to me, maybe they are too busy."
- People's religious needs were not always supported. We saw information in people's care plans about their religion, but these were not being addressed. We were advised the deputy manager was pursuing this for someone who had expressed a wish to be visited by a priest.
- We saw visitors to the home and relatives told us they were welcomed and could visit at any time. One relative told us, "They have a cup of tea ready for me and we have a laugh and joke."

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

- People were not always given the opportunity to make decisions. One person told us, "You have to get up at 6am, that's been the same since I came here." A relative told us, "They bring [person] into the lounge. They say it's better for her than being in her room alone."
- We observed people being offered drinks and snacks at set times. This meant people did not have choice or control in this area and the care offered was as part of a routine rather than in response to the person's needs.
- Some relatives told us they were involved in the initial care plan. However, when care plans had been reviewed there was no record of who was involved and what was discussed.

Respecting and promoting people's privacy, dignity and independence

- We observed one person's dignity was compromised. We observed they had a jumper stained with food and they had not been supported to clean their face. We visited the person later in the day and saw they were in the same condition. We followed this up with the provider during our inspection.
- Some practices within the service did not promote dignity and respect for people. For example, we saw people were given plastic beakers to have their drinks in whereas visitors had cups and there was a record of when people used the toilet with undignified language.
- People and relatives told us staff respected their privacy and dignity. One person said, "They knock the door even if they had just been in," our observations confirmed this.
- Staff knew the importance of keeping information confidential and people's information was stored

securely.

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 now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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's care plans were reviewed, but there was no evidence that people and relatives had been actively encouraged to be involved in discussing or reviewing care on a regular basis. This meant there was little evidence that people had any choice or control over their own support.
- There was some basic information in people's care plans about their life histories and hobbies. We did not see staff using this information to engage with people.
- There was an activity board on display but the activities on this board were not always provided. On the first day of inspection the activity board stated board games, however we observed a craft activity and a quiz being carried out which some people were engaging in and enjoying. On the second day the activity board stated nail care however, we did not see any activities being provided.
- People and relatives told us some activities were provided but more could be offered. One person said, "They try put the odd quiz on," another told us, "I can see the side of the TV not the screen not that they put anything on worth watching."
- We did not see evidence of person-centred activities being consistently provided or how people who were cared for in their bedrooms were involved in activities. Some of the things people told us they would like such as a paper, television guide and large print book, were not available to them.
- Staff told us there needed to be more activities on offer. One staff member told us, "There is not enough quality time." Another staff member told us in the past they had carried out reminiscence and done people's nails but it hadn't happened for a number of months. The provider told us they were currently recruiting an activity co-ordinator to improve care in this area.
- The provider told us they were in the process of recruiting an activities co-ordinator to improve the activities available.

Improving care quality in response to complaints or concerns

- People told us they knew how to complain and felt able to do so. One person told us, "They always say if you have a problem come to the office," a relative said, "I brought up a concern at the family meeting."
- The provider had a complaints process in place and we saw people received a written response to their complaints in a timely manner.
- Three written complaints had been made in relation to staffing levels and a relative told us this had also been raised at a 'family meeting'. The feedback we received on inspection from people and relatives were there was still not enough staff available. This meant there was limited evidence that care had been improved in response to these complaints.

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.

● Care plans contained information about people's communication needs but this needed improvement. One person's care plan said they could communicate but they "didn't make sense any longer". There had been no attempt to try and explore other ways to communicate with this person. We observed one person confused and disorientated and unable to understand what staff was saying to them. Staff did not appear to have the skills and knowledge to communicate with them in a different way.

End of life care and support

● Some people had end of life care plans in place however these were standardised and were not personalised. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now 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.

At our last inspection the provider had failed to ensure there were effective governance systems in place to identify concerns and drive timely improvements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17

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

- People's health and well-being was not sufficiently protected. Systems to monitor the safety of the service were inadequate and had not ensured people received care and support as required. As a result, people were not protected from risks associated with skin damage, choking, malnutrition, moving and handling, falls and distressed behaviour.
- People's medicines were not always safely managed. We found failings in the provider's quality assurance systems around medicine management, medicine errors were not always identified. Where systems had identified medicine errors they were not addressed effectively to ensure improvements were made.
- There were inadequate safeguarding systems in place. The registered provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made. As a result, some potential safeguarding concerns had not been reported to the relevant safeguarding agencies and CQC.
- There were ineffective systems in place to monitor accidents and incidents. There was no oversight or systems in place to analyse information and use lessons learnt to reduce the likelihood of re-occurrence. For example; we found one incident report identified most incidents were arising at night. The provider had not completed any further investigation, taken any corrective action and had not used the learning to drive improvements and minimise risk to people living in the service.
- Governance systems had failed to ensure risk assessments and care plans were up to date and provided sufficient guidance to staff to ensure safe care.
- The provider had failed to ensure there was a culture of continuous learning in the service. Some concerns which had been highlighted at the last inspection had not been addressed, for example where people were at risk of malnutrition and in relation to medicine management. We continued to have concerns at this inspection and could not see evidence of improvements made.
- Systems had failed to assess adequate staffing levels. People, relatives and staff told us they had concerns about the numbers of staff available to meet people's needs and our observations confirmed this.

● At the time of the inspection there was no registered manager as they had left in September 2019. The provider told us they had recruited a new manager and they would be in post shortly.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered provider had not appropriately submitted notifications to the Care Quality Commission. Whilst they had notified us of deaths and allegations of abuse they had failed to notify us of Deprivation of Liberty Safeguards (DoLS).

This is a breach of Regulation 18 (Registration) Notification of other incidents.

● It is a legal requirement that the overall rating from our last inspection is displayed. We saw the rating displayed within the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was no effective system in place to ensure that people were involved in reviews of care plans which meant the service was not consistently promoting person centred care.
● We found the provider had failed to develop effective systems to ensure people were fully involved in the development of the service. One survey had been issued in 2019 which a small number of people had responded to. There were no plans how to involve other people who may be unable to complete a survey.
● The registered provider had failed to ensure people received person centred and high-quality care which would lead to good outcomes for people. We observed care given was task-centred instead of person centred. There were no effective systems in place to ensure people were given choice and control over their care and daily lives.

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 registered provider was present during our visit and we shared our inspection findings with them. They took action in response to a number of the concerns raised, for example by increasing the number of staff at night time, updating care records and requesting an external medication audit.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and relatives told us there were 'family meetings' where they could discuss the service and any concerns. It was not always clear what action had been taken by the provider following the concerns raised.
● Most staff gave positive feedback about the support they had received from the 'office manager' and provider. Staff told us they received regular supervisions and had attended team meetings. However, when staff had raised concerns in relation to staffing levels, no action had been taken.
● The registered manager had recently left the service, some people were aware of this, other people told us they did not know who the manager was.
● The service did not always refer to other health care professionals in a timely manner and did not always follow their advice.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine management was not consistently safe. People were not protected from harm due to poor risk management processes within the service.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to identify and protect people from the risk of abuse were not effective.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure adequate staffing levels to meet people's needs.

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.