Farrington Care Homes Limited

Field House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Field House is a residential care home providing personal care to up to 28 people. The service provides support to older adults. At the time of our first inspection visit there were 14 people using the service and 2 people were in hospital. At the time of our second visit there were 19 people using the service. The care home accommodated people across 2 separate floors in one adapted building.

People's experience of using this service and what we found
New admissions to the service were not managed safely. Quality assurance systems did not always identify risks and issues to improve safety for people. Known risks were not always managed. Leadership of the service was inconsistent. Relatives did not feel engaged by the provider.

Incidents of alleged abuse were not always reported to the local safeguarding authority. Infection prevention and control (IPC) was not always safe.

Medicine-related recording was not always in line with best practice. Medicines management, however, had improved since the last inspection and people received their medicines safely. Relatives gave mixed feedback on the safety of the service. Staffing levels were safe, but staff skills were not always deployed appropriately. New staff recruitment was safe.

People's care plans sometimes included inconsistent information. People were supported to eat and drink, but some risks to people were not always highlighted effectively.

Some relatives felt the design and decoration of the building needed updating. We identified some improvements had been made to this since the last inspection. Staff understood people's needs. People were observed to enjoy their meals.

Staff had received up-to-date training to support people safely. Some lessons were learned from incidents to improve people's outcomes. The provider worked with other agencies to support people to achieve positive outcomes. Staff supported people in a person-centred way and relatives felt staff kept them up to date on people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 inadequate (published 25 August 2022). There were breaches in

regulation. This service has been in Special Measures since 25 August 2022. During this inspection, the provider demonstrated that some improvements have been made and the service is no longer rated as inadequate overall. However, we found the provider was still in breach of regulations and will remain in Special Measures as one key question has remained inadequate since the last inspection.

Why we inspected
At the last inspection, we carried out an unannounced focused inspection of this service on 25 May 2022. Breaches of legal requirements were found. The provider was served with a Warning Notice with a compliance date by when to improve.

We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Field House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the 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 monitor the service and will take further action if needed.

We have identified breaches in relation to people's health and safety, protecting people from abuse and governance.

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 work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is requires improvement. However, the service will remain in Special Measures. We do this when services have been rated as 'Inadequate' in any Key Question over 2 consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Field House

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 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
Field House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Field House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. There was a new manager in post who left the service during the inspection period. The head of care was subsequently appointed as manager during the inspection period with the intention to register as manager with the Care Quality Commission.

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 the local authority and partner agencies. We also used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
As part of this inspection, we spoke with the management team. This included the new manager who left the service during the inspection period. We also spoke to the deputy manager and a care consultant employed by the provider. We spoke with the head of care, who became the newly appointed manager, and 8 staff members. We also spoke with 2 directors and the operations manager as part of the feedback process during the inspection.

We spoke with 3 people using the service. We spoke with the relatives of 10 people and observed care and support at the service. We reviewed a range of written records including 5 people's care plans and risk assessments, staff recruitment and training records and information relating to the auditing and monitoring of service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.
Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to have systems in place to assess, monitor and mitigate risks related to people's care and support needs and infection, prevention and control. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people were not always assessed. For example, one person was known to present a safety risk following a recorded incident of alleged abuse. The provider had not put a risk assessment in place to address this risk to other people. Staff we spoke with were also not always aware of this risk and therefore how to best mitigate it. There had not, however, been any further recorded incidents of this nature.
● Infection prevention and control risks were not always managed effectively. There had been a COVID-19 outbreak at the service during our first inspection visit. People did not have COVID-19 risk assessments to help reduce the risk of infection. For example, 2 people were COVID-19 positive. We observed their bedroom doors open, which could present a risk of infection to others, but there were no COVID-19 risk assessments which addressed this risk to others. The management team told us both people would become distressed if their doors were closed, but these people also did not have risk assessments in place.
● Personal protective equipment (PPE) was not always used in line with best practice. We observed staff entering and leaving COVID-19 positive people's rooms without changing PPE. We also saw a staff member in the kitchen not wearing a face mask. This was not in line with best practice and risked spread of infection.
● Environmental safety risks to people were not always addressed. At the last inspection, we raised concerns about a stair gate being left unlocked as people at risk of falls could access the stairs and potentially fall. This stair gate was found to be unlocked at the first visit of this inspection.

Systems in place did not ensure risks related to people's care and support needs and infection prevention and control were assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acted following the inspection to address concerns raised by the inspector. Risk assessments were put in place for people where required. The management team addressed PPE concerns in a staff meeting to ensure best practice moving forward. A sign had also been placed on the stairgate to advise staff to keep it locked since the last inspection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene

practices of the premises
● Where risk assessments were in place, they contained clear information for staff to support people's care and support. The provider also had safety monitoring systems in place where there was risk, such as repositioning charts for people who could not mobilise independently.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

We have signposted the provider to resources to develop their approach.

Visiting in care homes
● Relatives were supported to visit the service in line with government guidelines. Relatives did not raise any concerns about restrictions on visiting people at the service. Relatives were also informed of the outbreak of COVID-19 at the service during the inspection.

Systems and processes to safeguard people from the risk of abuse

At out last inspection systems were not in place to protect people from the risk of abuse. This was a breach of regulation 13 (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Incidents of alleged abuse were not always reported to the local safeguarding authority to help keep people safe from harm. We identified 2 incidents of alleged abuse which were not reported. The provider had notified the Care Quality Commission (CQC) of 1 of the incidents, as required, but had not notified the local safeguarding authority.
● The second incident of alleged abuse which had not been reported, had occurred one week before the inspection. An incident report detailed a person being allegedly verbally abusive towards another person. The management team were not aware of this incident until it was raised by the inspector. Reporting systems in place had failed to highlight this incident to the management team so it could be followed up immediately to help protect people.

Systems had failed to protect people from the risk of abuse. This was a continued breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately following the inspection. They reported both incidents to the local safeguarding authority. The management team told us they had reported one of these incidents, but the local safeguarding authority confirmed they had not received this.
● We received mixed feedback from relatives about the safety of the service. For example, when asked if their family member was safe at the service, one relative said, "I think they are safe some of the time, they have had a recent fall... They are safe now." However, other relatives felt people were safe. Where relatives raised any concerns about safety, the provider gave us assurances about the support given to people.
● Despite the identified concerns, the provider had improved their systems for identifying incidents of alleged abuse since the last inspection. The management team now used a safeguarding tracker document which detailed the notification and outcome of any safeguarding incidents. The first above incident was present on this tracker.
● Staff had received recent training in safeguarding and demonstrated they knew what signs of abuse to

look out for.

Using medicines safely

● Medicines management had improved since the last inspection, but some recording did not follow best practice. We saw that 2 medicine administration records (MARs) for controlled drugs were not double signed. It is best practice for controlled drug administration to be witnessed and signed by a second competent staff member. We also saw that allergies stated on people's MARs were not always consistent with people's medicine profiles. The provider contacted the pharmacy about ensuring allergy information was consistent following feedback from inspectors.

● Systems were now in place to ensure as needed (PRN) medicines were administered safely. PRN protocols were detailed when staff should administer these medicines for people. There was also now a system in place for staff to record why PRN medicines were given which was in line with best practice.

● We observed staff supporting people to receive their medicines safely. The head of care explained to people that they were receiving their medicines and appropriate hygiene practices were followed.

Staffing and recruitment

● Staffing levels were safe, but staff skills were not always deployed appropriately. There was not always a medicines trained senior on shift at night, which was a concern highlighted at the last inspection. A member of the management team, who was medicines trained, was staying on-site at the service and supported with medicines to manage this risk. This was in place whilst new staff were being recruited and trained in medicine administration. The management team had also implemented an on-call duty staff member who could also be called to the service in the event of an incident.

● Since the last inspection, new staff had been recruited safely with information on work history and references completed.

● Staff had up to date Disclosure and Barring Service (DBS) checks in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

● The provider showed some learning from incidents, despite the concerns outlined above around risk assessments within the safe key question. For example, we reviewed a record for a person who had an unwitnessed fall. The service made a referral to health professionals and they now had a sensor in place to notify staff when the person got out of bed so they could support when needed.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection, systems had failed to protect people from being deprived of their liberty unlawfully. This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made improvements and was no longer in breach of regulation 13(5).

- People who were being deprived of their liberty had legal authorisations in place or applications pending. There was one person with a condition placed on their authorisation and this was being met by the provider.
- Mental capacity assessments were in place in people's care plans. These documented whether people were able to make decisions about their care independently or needed support from staff in their best interests.
- Staff members we spoke with understood principles of the MCA. We observed staff supporting people to make decisions and supporting people in their best interest. For example, staff supported people by prompting them to have a drink or food.
- Relatives also told us that staff asked for consent from people before they supported them. One relative said, "They do ask for consent to take [person] to the shower."

Staff support: induction, training, skills and experience

At the last inspection the provider had failed to ensure there were suitably trained staff employed to meet people's needs. This was a breach of regulation 18 (2) 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 18.

● Staff received up to date training, relevant to their role. Training records showed that staff were up to date with relevant training set by the provider. Some staff members we spoke with felt they would also benefit from continence care training. This was raised to the management team, who stated they would source this training for staff.
● Staff benefitted from shadowing (new staff observing more senior members of staff) during an induction period at the service. One staff member said, "Yes I shadowed for about a week. It was useful because the carer knows the residents and could explain what the person needs."
● Staff received supervision meetings to discuss their performance and development. Staff we spoke with told us they found supervisions useful and they were able to voice their own opinions and concerns if needed.
● Staff demonstrated to us that they understood how to meet people's needs when asked about people's care and support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Most people's needs were assessed effectively in care plans; however, some information was conflicting or needed updating. For example, one person's night-time care plan stated a call bell was to be kept by their bedside but also stated they were unable to use the call bell. Another person's review section of their care plan stated they used a 'bed wedge' (supports to stop a person slipping down the bed) but this had not been added to the main care plan and could have been missed by staff.
● The provider used recognised risk scoring tools for people in line with best practice. For example, the Braden Risk Assessment tool was used to support assessments of people's skin integrity and likelihood of developing pressure ulcers. This information was used to help inform care planning.
● Most relatives told us they were kept involved with discussions about people's care by staff. Talking about being involved in conversation about care, one relative said, "Yes we are, any changes I will always be informed."

Adapting service, design, decoration to meet people's needs
● Relatives gave mixed responses about the design and decoration of people's rooms. Some relatives felt rooms were personalised, while others felt they could do with updating. One relative raised their concern about the smell of the floor in their relative's room. Assurances were given by the management team that this was being replaced with a new and more suitable flooring material.
● Despite these concerns, we observed some improvements had been made to the design and decoration of the service since the last inspection. The conservatory area was no longer cluttered and was easier for people to walk around. A sunshade which was in a state of disrepair had also been removed from the conservatory.
● During the inspection, a notice board was being updated with information for people and staff. We also saw that there were displays of photos of people and relatives taking part in activities. One staff member told us, "There are display boards in the sun lounge with photos, with people painting and potting things. It's wonderful and uplifting to see."

● The environment included some adaptation to better support people's needs and be more dementia friendly. For example, doors had signs on them to support people to find their way around the service.

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

● Specific risks related to hydration were not always effectively highlighted. One person was assessed as having a risk of dehydration. Records over a 3-day period showed this person below their fluid intake target. On 2 of these days, this had not been highlighted on a handover record for staff starting the next shift. Although staff we spoke with knew the dehydration risks for this person and staff were observed offering drinks to this person, this presented a risk if staff did not know the person well. Updates were made to the handover system used following feedback from inspectors.

● We observed staff supporting people to eat and drink. For example, people were prompted by staff to drink fluids. We saw staff taking drinks to people who were isolating due to the COVID-19 outbreak at the service. Information was also available for staff in the kitchen to encourage food with a high fluid content.

● Staff were aware of people's dietary needs. Kitchen staff referred to a board which summarised any specific dietary requirements. Care plans also included information around specialised diets, such as one person who had a diabetic friendly diet.

● Relatives were positive about the food being offered to people. One relative told us, "The food is good. [My relative] is eating well and they are not losing weight." People were observed to enjoy the meals they were provided with.

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

● Working with other agencies was documented following concerns or incidents. For example, one person's care plan documented that their GP was contacted following a fall and they came out to check their health. The same person also had a recorded visit from a continence nurse.

● Relatives told us that staff supported people to access healthcare when it was needed. One relative told us, "[My relative] got their eye infection treated." Another relative, when asked if the home would support people to access healthcare, stated "Yes they would. [My relative] has had several visits to hospital."

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 we rated this key question inadequate. At this inspection the rating for this key question has remained 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.

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

At our last inspection, systems and processes were not established and operated effectively to ensure good governance. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Admissions to the service were not managed safely. Admissions had been suspended by the local authority following safety and governance concerns at the last inspection. During this inspection, the local authority partly lifted this suspension to limit admissions to 1 person a week. This was to ensure a gradual increase to the number of people and reduce pressure on the management and staff teams. On our second visit, the provider had admitted 3 people over a 5-day period, including 2 people in one day. This was in breach of the local authority contract agreement and put people at risk of unsafe care.
● The provider had failed to ensure their admissions process was followed safely, which was also identified as a concern at the last inspection. The provider's admission checklists stated care plans should be in place after 5 days of admission, but 2 people admitted did not have care plans after 6 days. This included a person who had shown repeated agitation since admission and put other people and staff at risk. The management team had failed to ensure people had their needs fully documented in a timely manner to inform safe care and support.
● Quality assurance systems had improved since the last inspection, but they did not always identify and act upon concerns. As outlined in the safe section, errors were found in medicine administration records. Errors had not been identified by the medicines audit, therefore no appropriate action was taken to improve staff practice and medicine related recording systems.
● The provider did not always address known risks. For example, a person was documented in an incident to present with a risk to others and this had been highlighted as a medium risk in the provider's risk analysis. The provider had not taken action to implement a risk assessment to inform staff of this risk and to reduce reoccurrence.
● The provider did not always follow their own systems and processes. The provider had not followed their own staffing dependency tool (a tool to inform safe staffing levels) and ensured a senior carer was on shift at night. The staffing dependency tool had also not been updated following a new admission at the service,

who had been at the service for 4 days. A staff member also told us they were concerned about a senior not being on night shifts, especially if more people came to live at the service.
● The provider's policies were not always followed. The infection prevention and control policy stated that risk assessments should be in place to protect people from the risk of infection. As reported in the Safe key question, the provider failed to ensure COVID-19 risk assessments were in place to help inform staff how to support and protect people.

Systems and processes were not established and operated effectively to ensure good governance. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider gave some assurances to concerns raised. The provider stated they would ensure admissions were limited to 1 person a week. As discussed in the safe section, some action was taken to reduce the risk of a senior not being on shift at night. We also saw that following feedback from the inspector, a senior was on the rota for night shifts moving forward.
● Care Quality Commission statutory notifications were not always completed in a timely manner as legally required. We are looking further into this.
● Despite concerns, some elements of oversight had improved since the last inspection. The provider had ensured that monthly audits were taking place and there was some evidence that these were improving the service and addressing issues. For example, the accidents and incidents audit detailed action which was taken to keep people safe from further incidents, such as falls.
● The provider had provided some support for the management team since the last inspection by employing a care consultant. The consultant worked with the management team at the service to improve systems and processes. This was evident in people's care planning, as well as the audits and analyses in place. Staff also told us they felt systems had improved since the last inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was inconsistency in the leadership at the service. There had been multiple covering managers since the registered manager left at the last inspection. Staff told us they relied on the support from the head of care and had concerns about management at the service. During this inspection, the manager in place also left the service. The head of care was consequently placed into the manager post to encourage more consistent leadership.
● Some relatives we spoke with were also concerned about the recent high volume of managers. Most relatives told us they did not feel engaged by the management team and had not had recent contact from them. Some relatives also told us when concerns were raised, these were not always listened to. We raised some of these concerns to the provider, the provider told us they planned to hold a meeting with relatives to discuss the ongoing management of the service.
● Staff felt engaged by the head of care, but this did not always extend to the management team. One staff member told us when a previous covering manager first arrived, they did not introduce themselves or their role. However, speaking of the head of care and another senior, a staff member told us, "They both take time to listen to you. If I need anything, they try and help me out. With them, it's a nice place to work." Another added, "[The head of care] has been a solid rock and has taken care of the [staff]."
● Staff supported people in a person-centred way and knew people's support needs. For example, one person was known to be at risk of dehydration and staff were observed to prompt this person to drink as much as possible. Staff also expressed a caring attitude towards people. A staff member told us, "The thing I enjoy most about the job is going to any person and leaving them in a mentally, physically or emotionally better situation than they were. Leaving them more comfortable."

Working in partnership with others; 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 provider worked with other agencies to achieve positive outcomes; this had improved since the last inspection. Contact with healthcare and social care professionals was recorded in people's care plans. The head of care gave one example where they raised concerns with the GP about a person being prescribed a high dosage of a new medicine without the dosage being built up. The GP conducted a medicines review and made changes to the prescription to reduce any negative impact on the person.

● Relatives told us the staff team worked with other agencies to support people. When asked about working with services, a relative told us, "Yes, that is something I am grateful for."

● We saw evidence of the management team following the duty of candour. It was recorded when relatives were contacted following incidents that occurred or when mistakes were made by the service.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's care and support were adequately assessed. Risks related to infection prevention and control were not effectively managed.

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 The provider failed to take adequate steps to protect people from the risk of abuse.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure admissions at the service were managed safely. Quality assurance systems did not always identify and action issues at the service. Known risks were not always addressed by the provider and policies, processes and systems were not always followed.

The enforcement action we took:

Notice of Proposal to impose conditions.