Corvan Limited

Cordelia Court

Inspection report

182a Shakespeare Street
Coventry
West Midlands
CV2 4NF

Tel: 02476636868

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

Summary of findings

Overall summary

About the service
Cordelia Court is a residential care home providing accommodation and personal care for up to a maximum of 34 people. The service provides support to adults under and over the age of 65 who may live with dementia or a sensory impairment. At the time of our inspection visit, there were 32 people living at the home.

People's experience of using this service and what we found
Risk management associated with people's needs and the environment needed improvement. Risks were not always identified, monitored, or acted upon to ensure people's safety. Medicine records lacked detailed information to confirm safe management. Staffing arrangements were not always effectively managed to support people's needs. People had mixed views of their experiences of care.

Staff understood their responsibility to report any concerns to protect people from the risk of abuse. However, records relating to incidents and accidents were not always effectively maintained to identify and act on risks. Actions were needed to ensure temporary staff working in the home were safe and suitable to work with people. Areas of the home needed attention to ensure safe infection, prevention, and control.

New staff completed an induction to the home, and all staff were able to access essential training although this needed updating for some staff. Staff told us they had supervision meetings with the manager to support them in their role. 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. However, records were not always clear around decisions made. People's nutritional needs were assessed, and staff offered support to people where needed. There were some choices of meals provided.

People spoke positively of some staff but told us there was an inconsistency in staff approach in how they were supported. We saw practices within the home that did not support people's privacy, dignity, and independence.

People's needs were assessed and reflected in individual care plans, but the level of detail was not consistent to support staff in providing person centred care. However, staff knew people well. There were some social activities provided and some people were supported on visits outside of the home.

Governance systems, management and provider oversight of the service were inadequate. The quality and safety of the service continued not to be effective. Whilst there were systems and processes to monitor the quality of care and services provided, areas needing improvement were not always identified and acted upon. Records were either not consistently maintained or were not in sufficient detail to show incidents had been safely and effectively managed. Staff were positive in their comments of the manager and felt supported in their roles.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 March 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
You can see what action we have asked the provider to take at the end of this full report.

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 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

Cordelia Court

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.

Inspection team
The inspection was carried out by two inspectors and an expert by experience who visited the home. 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
Cordelia Court 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. Cordelia Court 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 no registered manager in post. A new manager had been in post for four months and intended to submit an application to register.

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 who work with the service. We 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
We spoke with 12 people who used the service and 6 relatives about their experience of the care and support provided. We spoke with 5 staff, including the manager, about their role and experiences of caring for people at the home. We reviewed a range of records. This included four peoples care records, multiple medicine records, training records, quality monitoring records, accident and incident records, and multiple records relating to the management of the home. We observed people to help us understand the experience of people who could not talk with us.

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 Requires Improvement. At this inspection the rating for this key question has remained 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

- Risks associated with people's care and the environment continued not to be effectively assessed and managed. Records were not always clear to support staff in managing risk.
- One person did not have care plans for each of their needs to support staff in providing safe care. They were at risk of falls, but all risks associated with these, including a health condition, had not been assessed. The falls risk assessment did not mention important actions staff should take in response to the person falling to keep them safe. The person had not come to harm from falling at the home at the time of our inspection.
- Environmental risks were not effectively managed to keep people safe. In one bedroom flammable items had not been stored in accordance with instructions increasing the fire risk. We moved these items. The fire doors to the laundry and visitors room were wedged open which meant they would not automatically close in the event of a fire. There were damaged items of furniture that placed people at risk of injury, and unsecured wardrobes increasing the risk of them falling on to people.
- Recruitment checks for temporary staff working at the home had not been completed to ensure they were safe to work with people. The manager made arrangements during our visit to obtain this information.
- One person with dementia was described as being "aggressive" and for staff to "monitor" their behaviour, but it was not clear how the person's behaviour presented. There was very limited guidance to help staff support the person at such times or reduce the persons levels of anxiety and maintain their wellbeing.

Risk management was not sufficiently robust to prevent people being placed at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection visit, action was taken by the manager to address immediate environmental risks including arranging for wardrobes to be secured and items of broken furniture to be fixed. Fire doors were closed, and staff advised of fire safety practices.

Using medicines safely

- Medicine management was not managed safely consistently, and audit checks had failed to identify this.
- One person was prescribed two different types of eye drops. Prescribing instructions had not been followed for both medicines meaning the person was placed at risk of ongoing discomfort. This was not promptly reported to the GP on the same day it was identified to ensure any negative impact on the person could be assessed and addressed.

● Topical creams were not stored safely. Some were in people's bedrooms where people with dementia could have potentially ingested them. Some creams did not have prescribing labels to help ensure they were applied to the right person. Some contained no dates of opening to prevent them from being used beyond their effectiveness date.
● Medicine stock counts did not match what was recorded on the medicine administration records. In some cases, there were less tablets than there should be. This meant people may have been given more medicine than they should and there was a risk medicines would run out before the start of the new cycle.

Medicines were not managed safely which placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager reviewed medicine records following our inspection visit to help ensure discrepancies were addressed. Medicines stored inappropriately were moved to medicine cabinets to ensure they were safely stored.

Preventing and controlling infection
● We were not assured the provider was preventing visitors from catching and spreading infections. Visitors were not consistently asked to sign in, have a temperature check, wash their hands, or advised about where to wear a mask. The manager told us they had taken to address this following our inspection visit.
● We were not assured the provider was supporting people living at the service to minimise the spread of infection. Communal areas were not spaced to allow social distancing. Access to hand washing facilities in some people's bathrooms was prevented by equipment storage. The Covid-19 Outbreak policy made no reference to supporting people in groups in the event of an outbreak
● We were not assured that the provider's infection prevention and control (IPC) policy was up to date. The manager was not able to locate an IPC policy, this meant it was not accessible to the manager or to staff to ensure they provided care in line with the guidance.
● We were not assured that the provider was admitting people safely to the service. A person who had been in hospital tested positive for Covid-19 was admitted to the home with no testing to check if they remained infectious. The person was not isolated to their room following admission, however this had not led to the spread of Covid-19 at the home.
● We were not assured the provider was responding effectively to risks and signs of infection.
An IPC policy was not available to view which meant staff were unable to refer to this to ensure if a person was symptomatic for an infection.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were either not available or not completed regularly to confirm cleaning had taken place. Clean and dirty laundry was not stored according to good IPC practice. Equipment used within the premises and furniture was often dirty and/or damaged.
● We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. Although staff had received IPC training, this was not put into practice resulting in poor practice and a lack of cleanliness in the service.

Infection, prevention and control was not effectively managed which increased the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was using PPE effectively and safely. Most staff wore PPE appropriately. Improvements had been made to the storage of PPE however we saw some disposable aprons draped over a handrail.

● Following our inspection visit, the provider initiated an action plan to address infection, prevention, and control issues that we had found. This included closer monitoring of arrangements to manage IPC and action to locate the IPC policy. Action was also taken to ensure access to handwash basins and all cleaning schedules to confirm cleaning had been completed.

Systems and processes to safeguard people from the risk of abuse

● A system for reporting safeguarding incidents to other agencies such as the Local Authority and CQC was in place. However, records lacked sufficient information to identify if they met the threshold for reporting where further actions may be taken to prevent any ongoing risks. The manager stated they would address this.

● People had mixed experiences of care and support which impacted on them always feeling safe. One person told us "Some staff are not so good, rude, they don't always want to help." A relative said, "The staff are friendly, they are happy for [Name of person] to sit with them."

● Staff told us they knew how to identify abuse and would report safeguarding concerns to senior staff members or management for escalation.

Staffing and recruitment

● Staffing arrangements were not always effective to support people's needs. Both people and staff commented staff were not always available to provide support. A dependency tool used to determine the number of care staff needed had not been completed accurately. Following our visit, the provider increased ancillary staff support at the home so care staff could focus on care and support.

● People felt staff were sometimes responsive to their needs, and at other times, were not. People spoke of different approaches of staff. One person said, "I shouted for ages for help to go to the toilet, but it took them 10 minutes to get here, but they are busy."

● Staff told us they felt more staff were needed because the home was fully occupied. One staff member told us, "We need more staff, we need more staff because we have more residents." Temporary agency staff were used to support the home where needed.

● Recruitment checks were completed for permanent staff prior to them working at the home to ensure they were suitable to work with people.

Visiting in care homes

● Visiting was supported at the home . A visitor's room was available to family members if they wished to use this.

Learning lessons when things go wrong

● The lack of managerial oversight meant areas needing improvement had not always been identified to help ensure lessons were learnt when things went wrong.

● Staff told us they would report accidents or incidents but there was no clear system to monitor, manage and reflect on incidents to prevent reoccurrence.

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 Good. 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed before they had started to use the service. This process included people's relatives where possible.
- People's assessments had considered the protected characteristics under the Equalities Act 2010 which included cultural needs. There were both male and female care staff working at the home to help support people's preferences.

Staff support: induction, training, skills and experience

- Staff completed online training, but training information showed not all staff were up to date with training considered essential including training linked to people's needs such as dementia. One staff member told us, "Carers knowledge is weak, they do training online."
- Staff competencies had not been effectively tested following training. For example, medicine trained staff had not recognised unsafe storage of creams. Staff who had completed health and safety training had not recognised flammable Items stored on top of a radiator was a fire risk. A cleaning trolley with chemicals had been left unattended not recognising this placed people at risk of harm if they ingested them.
- Staff told us they had an induction when started work at the home, but a record checked for a new staff member contained a blank induction record and there were no training certificates to confirm induction training such as The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

- People had access to food and drink but not always at times of their choosing. Meal choices were limited although people said they were generally satisfied with the food provided.
- One person told us, "Not much variety at lunch", we asked if they had raised this and they said, "Yes, but no change." Another said, "Food is good, really."
- One person's care records showed during the night they had called out in "hunger" until staff provided them with a cup of tea and a biscuit. A supper menu was in place but none of the staff spoken with knew if this was provided. The cook stated they did not prepare this, but care staff had access to the kitchen.
- Menus contained limited information to confirm vegetarian choices were made available to people. For example, one evening meal option was chicken sandwiches or soup. Another was corned beef and pickle sandwiches or chicken soup. Staff told us jacket potatoes were always available.
- The cook was aware of people who required specialist diets and increased calories. Milk powder was

added to some foods such as mashed potato to help increase nutritional intake for those people at risk of ill health due to not eating enough. Support was provided to people to eat but this was not always timely. Staff said this was because they wanted to support people's independence.

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

● People had been referred to other healthcare professionals and agencies to support their needs and wellbeing. This included doctors, dieticians, and the district nursing team. However, the advice healthcare professionals had provided had not always been incorporated into people's care and risk management plans to ensure this was followed.

● One person seen by a dietician was to be weighed every 2 weeks due to concerns related to their health. The care plan did not contain instructions for staff to do this, and this had not been done.

● Staff told us they reported any concerns or changes in people's health to management staff so they could inform other agencies or health professionals as appropriate.

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

● The home has been adapted to support the needs of people living there. This included a new extension built onto the existing home with added communal areas. The décor, in the older part of the home needed improvement.

● Some people's ensuites were used as storage areas preventing people from using them. Some ensuite toilets had no toilet roll holders meaning a person would have to stretch to reach them placing them at risk of falling.

● People who smoked went outside but there was no smoking shelter available to support people to smoke in inclement weather.

● Hallways and doorways were wide enough to allow people to use specialist equipment, such as wheelchairs. The upper floor was accessible by a lift or stairs. There was a communal garden which was level to enable people using wheelchairs to access.

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.

● Legal authorisations to deprive a person of their liberty had been applied for and were in place for those people who lacked capacity. However, despite staff training, staff were not fully clear in their understanding of the MCA and DoLS.

● Assessments did not contain sufficient detail to explain why a person did not have capacity. The assessments used generalisations based on a person's diagnosis of dementia as opposed to evidence to support why the person could not make a decision.

● One care plan contained conflicting information regarding the person's capacity which meant it was not clear how the person may need support with decisions.
● Staff were not fully clear of what the MCA and DOLS were but asked people for consent before providing care demonstrating some understanding.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for, or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- Systems in place did not always support people's privacy and dignity, but people who wished to be more independent were supported where possible.
- During our tour of the home we identified ensuites with damaged doors and handles which meant people's privacy and dignity was compromised. The provider told us these would be repaired.
- A relative of a male person in the home told us, "He doesn't like pink bedding and they have put some on today" which demonstrated a lack of person-centred care to maintain the person's dignity.
- Continence products were left on view in people's rooms compromising people's dignity.
- Over chair tables used at lunch time had been placed too far away from some people resulting in them dropping food onto their laps. This did not support people's dignity.
- Arrangements to keep people's confidential information private were not sufficient. People's care information was either left out or stored in open cupboards in communal areas of the home where others could access this. The manager told us the cupboard would be swapped for one that locked, and staff reminded not to leave out confidential information.

Failure to have suitable arrangements in place to protect people's privacy and dignity was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Those people who had capacity were supported to make outside visits such as to the shops with staff support where required.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
- People had inconsistent views about whether they felt staff cared about them and valued them as individuals. While some staff were observed to have a caring approach to people, the overall management of the service meant care and support may not always be given in ways people preferred, or in a caring way.
- One person was sat in the corridor visibly anxious and needing support. They said, "No one is ever here". Staff walked by and there was no interaction with the person. Their walking frame was visibly dirty, and we requested this be cleaned.
- A relative told us, "The television was off when we came in, and [Name of person] was just slumped in the chair but look they have perked up a bit now I've put it on" suggesting staff were not always considering people's needs and wishes.

● When we asked people about their experience of living at the home they would typically respond, "its ok". However, some relatives spoke positively of the care provided. One told us, I'm overall impressed about it here, I like it. It's homely."
● People had some involvement in decisions about their care, those that were unable to make certain decisions, were supported by staff.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. 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

- People had some choices about how their care was provided to meet their needs and preferences, but care records did not always support staff in providing personalised care.
- Staff told us they relied on care plans for guidance on how to meet people's needs and preferences, but these were not always fully completed. One person did not have care plans in place for all of their needs. Action was taken following our visit to address this.
- We could not be confident people's individual needs were always being met as daily records sometimes contained conflicting information. For example, one entry stated, "[Person] was fine today" but this was followed with information stating the person did not eat well and was very agitated.
- Staff knew people's likes and dislikes and were able to tell us how they supported people's needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The manager was not fully aware of the Accessible Information Standard but understood the importance of people with disabilities or sensory loss being supported with their communication needs.
- During lunchtime we saw staff were not able to effectively communicate with some people as people questioned what they were being asked. Relatives told us of their challenges in communicating with some staff. One told us, "If we ring at the weekend, the phone just rings and rings, and staff cannot always understand me." We made the manager aware of this to ensure this was addressed.

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

- Staff supported people to engage in social activities provided both at the home and in the local community. Some people chose not to participate in activities at the home and staff respected their choices.

- Some people didn't feel their social needs were met. One person told us, "They don't do anything with you and there is no-one to talk to." Another said, "I would have liked it more if less people here had dementia, as I couldn't talk to many people."

Improving care quality in response to complaints or concerns

● A complaints procedure was in place, but the manager told us she managed any concerns and complaints as they arose but did not necessarily record them. The manager accepted it was important to record any concerns to demonstrate they had been acted upon and resolved.
● During our visit both people and relatives raised issues they were not happy about. This included concerns about other people's laundry items in their room and not receiving items back from the laundry. Records failed to identify issues such as this to show they had been acted upon, and to demonstrate there was an effective system in place to respond to concerns.

End of life care and support
● No one living at the home at the time of our inspection was at the end stage of life.
● Some staff had completed end of life care training so they would know how to support people at the end of their life. Some care plans contained information about people's end of life wishes.

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 Requires Improvement. At this inspection the rating has changed 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.

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 the provider had failed to have robust systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities).

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● Risks were not effectively managed as monitoring systems were ineffective. The provider failed to have effective oversight of the service. The quality and safety of the service continued to require improvement.
● Systems to identify environmental risks continued not to be effective placing people at risk of potential harm. For example, the laundry door had a notice on it 'Fire Door Keep Shut' but laundry items continued to be hung over the door and it was also wedged open preventing it from closing in the event of a fire.
● Audit systems failed to identify unsafe broken items of furniture in bedrooms, unsafe wardrobes that were not secured to prevent the risk of them toppling over and harming people. Substantial fire risks had not been swiftly acted upon to minimise risks to people in the event of a fire.
● Audits of medication and care plans had not identified risks we had found. This included medicines not given in accordance with the prescriber's instructions increasing the risk of people's healthcare needs not being met. The unsafe storage of medicines increased the risk of people accessing and potentially ingesting them causing them harm. There were, inaccurate or missing care plans, which meant staff did not have the information they needed to care for people safely. This included no information on how to support a person who had a blood condition that could cause them harm should they sustain an injury.
● Systems to record accidents and incidents were insufficient to ensure regulatory requirements were met. It was not clear from information recorded if accidents needed to be reported to other agencies to ensure risks to people's health and wellbeing were safely managed.
● Audit processes had not identified people's care records were not kept secure and staff were completing daily notes retrospectively. This meant it was not clear when care interventions had taken place to demonstrate care plans were followed and safe care had been provided.
● Audit systems had not identified that staff were not working safely to ensure people's needs were met. For example, medicine trained staff had not recognised unsafe medicine management; staff who had completed health and safety training were not identifying unsafe work practices such as leaving fire doors

open.

Systems to improve the quality and safety of the service people received were not sufficient and placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection the manager in post was not registered with us. The provider had taken the necessary action to submit a registration application to us for consideration.
● The manager advised following our visit, action had been taken to ensure immediate risks including fire and unsafe wardrobes were addressed.

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
● Many people living at Cordelia Court were not able to comment on their experiences of living at the home due to their dementia. However, we observed people did not always receive person centred care. For example, two people were seen attempting to sleep resting their heads on their over chair tables. Staff walked past them but did not attempt to either ask if they wanted to move to their bed or provide cushions or pillows to make them more comfortable.
● People had opportunities to attend meetings but those who had attended did not feel they had resulted in any changes to improve the service.
● Staff mostly felt supported at the home and spoke positively of the manager. Comments included, "[Manager] is very kind lovely lady, "I like to work with [Manager], she is very kind. A relative said, "[Manager] is great, but she is pulled from pillar to post" referring to them always being busy.

Working in partnership with others
● The manager worked with other agencies such as the local authority and health authority, to support people's needs.
● The registered manager told us they liaised with other registered managers to support them in their role and to help improve people's experience of care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager recognised the importance of being open and honest when things went wrong but systems and processes in place had not resulted in learning from incidents to educate staff to prevent reoccurrence. The manager told of plans to improve this.

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 10 HSCA RA Regulations 2014 Dignity and respect Suitable arrangements were not in place to protect people's privacy and dignity. Regulation 10 (1) (a) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not sufficiently robust to ensure risks were safely and effectively managed. Regulation 12 (1) (a) (b) (c) d) (g) (h)

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 Systems and processes to monitor and improve the quality and safety of the service were not sufficient and placed people at risk of harm. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning Notice