

Georgian House (Torquay) Limited

Georgian 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?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Georgian House is registered to provide personal care and accommodation for up to 43 people who may have needs associated with their physical and/or mental health. At the time of the inspection, there were 33 people living at the home. Georgian House is also registered to provide personal care to people in their own homes. At the time of the inspection, there was no one receiving care in their own home, so this activity was not included in this inspection.

People's experience of using this service and what we found

The majority of people told us they were safe, happy, liked living at Georgian House and were well cared for by kind and caring staff. We received mixed feedback from relatives regarding people's experiences. Most relatives told us they did not have any concerns for their loved one's safety. However, two relatives told us they did not have confidence in the care people were receiving or the management team. These concerns are being dealt with under formal complaints and safeguarding procedures and CQC will be informed of the outcome.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

We found the service was not always operating in accordance with the regulations and best practice guidance. Some systems were either not in place or had not been undertaken robustly to identify and monitor the quality of the service and drive improvements. This meant some systems operated by the provider had failed to identify concerns and shortfalls we found during this inspection and could not be relied upon as a source to measure quality and risk.

Safeguarding systems were established and the provider had clear policies and procedures in relation to safeguarding adults. However, we found safeguarding processes did not always operate effectively.

People were not always protected from the risk of avoidable harm. We found where some risks had been identified, enough action had not always been taken to mitigate those risks and keep people safe.

People were not always supported to have maximum choice and control of their lives and staff were not always supporting people in the least restrictive way possible. The service could not always demonstrate they were acting in people's best interests.

Most medicines were given safely and correctly. Some improvements were needed and these were being

implemented.

People did not always receive their commissioned individual support hours.

People were mostly supported by staff who had the skills and experience to meet their needs. However, we found there were gaps in training and some staff had not completed a full induction.

People's needs were assessed prior to admission.

Staff knew people well and understood how to communicate effectively with people and spoke about people in a dignified and respectful way.

The registered manager was keen to put processes in place to address any areas of concern or improve practice. The provider had identified particular areas such as compliance, staff welfare, learning and development as areas they needed to focus on.

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 good (published 27 September 2019).

Why we inspected

This inspection was prompted by a review of the information we held about this service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

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 good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Georgian 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 safeguarding, safe care and treatment, staffing, the need for consent, notifications and governance at this inspection. We have also made recommendations in relation to Fire safety and person-centred care.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-led findings below.

Georgian 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

The inspection team consisted of two adult social care inspectors, a medicines inspector and two Experts by Experience who had consent to gain feedback on the care provided by the service from people and their relatives. 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

Georgian House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Georgian House is also registered to provide personal care to people in their own homes. At the time of the inspection, there was no one receiving care in their own home, so this activity was not included in this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

The first day of this inspection was unannounced.

What we did before the inspection

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 information gathered as part of monitoring activity that took place on 28 June 2022 to help plan the inspection and inform our judgements. We reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

During the inspection

We spent time with and spoke with 11 people living at the service, nine relatives, 12 members of staff, the registered manager and the providers/owners of Georgian House. To help us assess and understand how people's care needs were being met we reviewed seven people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems. We also spoke with and received feedback from partner agencies.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, policies and procedures and we spoke with a representative from the local authority.

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 good. 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.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at Georgian House. Comments included, "Yes very safe," "Happy, feel safe," "I feel safe and well looked after," "The staff look after me" and "Sometimes I do, sometimes I don't."
- We received mixed feedback from people's relatives. Most of the relatives we spoke with told us they did not have any concerns for their loved one's safety. However, one relative told us they believed their relation was at risk, they had raised their concerns with the provider and local authority who were in the process of investigating their concerns.
- We found safeguarding systems were established and the provider had clear policies and procedures in relation to safeguarding adults and the use of restraint. However, we found safeguarding processes did not always operate effectively.
- Records for one person indicated that staff had failed to recognise and report to the local authority safeguarding team an allegation of poor practice by an agency member of staff which had led to an infringement of one person's rights.
- An investigation completed at the time failed to fully consider the impact this incident may have had on the person; take appropriate action with all staff involved or see this as a learning opportunity.
- Staff had recorded nine safeguarding incidents between May 2022 and August 2022. All these incidents had been recorded on the providers incident reporting system; however, they had failed to report them to the local authority in accordance with procedures, for further investigation and follow up.

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

- Following the inspection the registered manager confirmed they had undertaken a review of all incident records. They had shared all relevant information with the local safeguarding team and were making changes to the way the current system was operating.
- Records showed the service had made other safeguarding referrals in line with the services policies and procedures.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of avoidable harm as staff did not always have all of the information needed to meet people's needs safely. For example, information gathered as part of one person's pre assessment process did not form the basis of their risk assessments. While senior staff were aware of the information and understood the risks. Staff had not been provided with enough information to keep this person and others

safe.

- Where risks had been identified, it was unclear what action had or was being taken to mitigate those risks and keep people safe. For example, where one person had been declining personal care, their risk assessment required staff to record when they offered assistance and the outcome of this in order to monitor and review. However, daily records did not always evidence that staff were recording this information. This meant the registered manager and staff could not evaluate strategies used to encourage compliance and reduce the risk of skin damage.
- Records showed accidents and incidents were being recorded. However, this information was not being analysed or reviewed. This meant the provider could not be assured that lessons had been learnt or enough action had been taken to keep people, staff and others safe from harm.
- People did not always receive their medicines as prescribed. Medication administration records (MAR) showed three gaps in one person's records where we could not tell if the medicines had been given.
- One person's care plan did not match with the prescriber's instructions on their medicine's administration record.
- We also saw one person whose medicine was prescribed 'when required' who was being given this regularly.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We reviewed the service's fire safety precautions. Records showed that routine checks on fire and premises safety were being carried out within the required period. However, we noted the services fire risk assessment had not been updated following a change in the environment.

We recommend the provider reviews their fire safety risk assessment to ensure they are following current best practice guidance.

- Other risks to people's health and wellbeing were being managed well. Detailed care plans and risk assessments were completed in areas such as mobility, moving and handling, managing people's emotional distress and skin integrity.
- Where people were at risk of pressure damage to their skin, appropriate equipment was in place to reduce this risk. For example, pressure relieving mattresses and cushions. Staff understood these risks to people's safety and welfare and knew what action they needed to take to mitigate them.
- People were protected from risks associated with their environment as routine environmental checks were regularly taking place. For example, window restriction and water temperature checks.
- A new system had been put in place for recording the administration of creams and external preparations. This meant staff accessed directions for each preparation and recorded the application of each named product separately and reduced the risk of people not receiving their creams as prescribed.
- Staff received training and had competency checks to make sure they gave medicines safely.
- There were suitable arrangements for ordering, storage, recording and disposal of medicines, including those needing cold storage or extra security.
- Regular medicines audits took place, and areas for improvement were identified, and recorded when completed.
- There was a system in place for recording, reporting and investigating any medicines errors or incidents. Improvements were put in place to reduce the chance of them reoccurring. Medicines policies were in place and were under review at the time of our inspection.

Staffing

- We received mixed feedback about staffing levels. People were not able to tell us if there were enough staff

to meet their care and support needs. However, one relative said, "I do not believe [person's name] is getting the correct amount of one to one hours and only some of the two to one hours they are funded for."

- A healthcare professional confirmed people were not receiving their funded one to one support. We reviewed staffing rotas which demonstrated people did not receive their commissioned support hours. This meant we could not be assured people's care and support needs were being adequately met.

The failure to provide sufficient numbers of staff to meet people's care and treatment needs, placed people at an increased risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was aware of some of the concerns regarding one to one and two to one support and explained they were developing new software with an external company. They told us this would provide increased oversight and enable them to provide real time information to healthcare professionals.

Learning lessons when things go wrong

- Systems were not fully embedded into care practice or robust enough to demonstrate accidents and incidents were effectively monitored, reviewed or used as a learning opportunity. This meant, the potential for re-occurrence had not been sufficiently well managed because insufficient action had been taken to review, investigate or learn lessons.

Systems to assess and improve the quality and safety of the service were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. During a tour of the service with a senior member of staff we noted that none of the designated donning and doffing areas contained a clinical waste bin for staff to dispose of their used PPE. We discussed what we found with a senior member of staff who told us they had been taken away to be emptied.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

The provider was facilitating visits for people living in the home in accordance with the current guidance. The provider had built a visiting 'Pod' in the grounds which people told us they were able to use to have regular visits with friends and family. Relatives we spoke with, told us they had been able to visit their relations regularly. One relative said, "I visit my son weekly using the special POD." Another said, "I can ring at any time. I will ring to confirm what time I am coming to visit mum and I am able to see her in the POD. Love it there, no problem. "

Recruitment

- People continued to be protected by safe recruitment processes.
- We looked at the recruitment information for four members of staff and found systems were in place to

ensure staff were recruited safely. This meant the provider was able to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staff support: induction, training, skills and experience

- People were mostly supported by staff who had the skills and experience to meet their needs safely.
- The provider monitored staff training using a training matrix which identified staff had received training in a variety of subjects. However, we found there were significant gaps in the training some staff had undertaken and some staff had not completed an induction in line with the Care Certificate Standards. 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.
- Most staff spoke positively about the service's induction process and told us they had a thorough induction. However, some staff did not know when asked who their supervisor was or why their induction books had not been completed/signed off. One member of staff said, "The induction process is not very organised. I am meant to be shadowing at the moment, which I am not and I have someone assigned to shadow me. It doesn't make sense."
- We discussed what we found with the registered manager and providers who told us they had recently employed a number of qualified Nurses from overseas. However they were unaware that some staff were not completing the services induction process in line with their expectations.

The failure to provide adequate support and training to staff in order to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had opportunities for regular supervision and appraisal of their work performance. Staff told us they felt supported and appreciated by the service's management team. One member of staff said, "I feel very supported here."

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Through discussion we identified that some members of the management team did not always have a good understanding of the Mental Capacity Act and DoLS process. This lack of understanding had led to one person having restrictions placed upon them without legal authorisation. This showed knowledge of the legal basis or framework to support this type of decision making needed improvement.
- The registered manager told us they had carried out a best interests decision to hold one person's money for safety reasons without first undertaking an assessment of this person's capacity to manage their monies.
- We reviewed people's capacity assessments and best interests decisions, we found some assessments lacked detail and did not contain sufficient information about what information had been discussed or how people were being supported to understand, retain, weigh up or communicate their decision.
- One person's MCA was not decision specific and appeared to show the outcome had been reached before the MCA was undertaken. This person's best interests decision documentation contained conflicting information about the person's capacity.
- The use of CCTV in the communal areas of the home had been discussed with most people. However, it was not clear from these records that the service had fully discussed the scope, use and the sharing of CCTV with external bodies or how this may impact on people's rights. This meant people had not been given all the information in order to make an informed choice, nor was this information documented as part of people's best interests decisions.
- We discussed what we found with the registered manager, who acknowledged there was still some learning that needed to take place in relation to MCA.

The failure to properly assess and record people's capacity and best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People who wanted to share their views with us said, they enjoyed the meals provided by the service and could make decisions about what they ate and drank and when. Comments included, "The food is good," "Nice choice," "You can have the food you ask for" and "Food is alright but the meals are never on time."
- We received mixed feedback from relatives regarding meals. For example, one relative said, "[Person's name] gets what they want," "good choices every day," "they know the person's preferences" and they get good-sized portions." Another relative said, their relation did not like the food, they had lost weight since living there and had complained about the meals provided."
- People's care plans detailed the support they required from staff to eat and drink. Where people had specific dietary preferences or needs, this was highlighted for staff to follow and included any guidance received from external health professionals such as speech and language therapists.
- Staff identified people who were at risk of malnutrition and took appropriate steps to support them, which included recording and monitoring people's weights, fortified diets and referrals to dietitians.
- We observed the mealtime experience and found more work was needed to ensure people's mealtime experience was a pleasant and dignified one and they were supported in a person-centred way. For example, we saw one person in the main dining room who was eating independently. However, much of the food was going down the front of their clothes and onto the floor. Although staff were present no assistance was offered.

We recommend the provider ensures the impact of staff training is monitored to ensure it remains effective in promoting person centred care that ensures people's dignity is promoted at all times.

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

- People's care plans contained key information about their physical and mental health to inform staff and guide them on how best to support each person.
- People were supported to access a range of health care professionals to enable them to live healthier lives. This included access to GP, physiotherapist, occupational therapist, dietitian and speech and language therapist (SALT).
- Records showed staff made referrals to health care professionals and any guidance provided was used to update people's care plans. This helped to ensure staff had a good understanding of how people should be supported to manage any existing health condition or change in their needs.
- However, we received mixed feedback from relatives and healthcare professionals regarding the timeliness of seeking external support. Some relatives told us the service was quick to seek advice. One relative said, "[Person's name] has regular seizures, staff are quick to respond and let me know ASAP." Other relatives did not feel the service worked well with other agencies or kept them informed. For example, one relative said, "Staff fail to attend regular meetings and have not kept us informed." A healthcare professional said, "Staff have not always recognised the need to seek advice or escalate concerns to external professionals."

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

- People's needs were assessed prior to admission. Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practice. Information from these assessments were mostly used (see safe section of this report) to develop individualised care plans and risk assessments which provided staff with guidance about how best to meet those needs in line with people's preferences.
- People we spoke with did not appear to be aware of their care plans or if their relations had been involved in their development. Most relatives told us they felt the home communicated well with them and kept them updated when things had changed. One relative said, "The manager had run through changes to her father's care."

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

- Georgian House is an adapted period property set in a quiet area of Torquay. The main communal areas of the home were warm and clean.
- Most of the bedrooms offered single occupancy and had en-suite facilities. Communal toilets and bathrooms were available throughout the service.
- Electronic locks accessed by key fobs provided security for people's belongings and allowed access to the residents' kitchen for those people who had been assessed as safe to do so without staff support.
- People's rooms were personalised and decorated with personal effects and were furnished and adapted to meet their individual needs and preferences.
- The garden was secure and designed with items of interest for people to enjoy such as musical instruments and a table tennis table. For those people who preferred to spend time outside, sheltered areas had been created where people could sit and chat.
- However, people told us the environment could be very noisy. Comments included, "It's very noisy," "It's hard to think." "I don't get a minute's peace. And "It's noisy a lot of the time and I have to put up with it."
- Throughout the inspection the inspection team noted the environment appeared to be very busy at times, mainly due to the numbers of people and staff. This could possibly be having a negative impact on the people living there.
- We discussed what we found with the senior management team and one of the providers, who told us they had recognised the impact this was having on people. They explained this was one of the reasons they had employed the new head of support. They said, "Now we are out of the pandemic people needed to be supported to get out and about more and get back to normal as both people and as staff had got used to

staying in."

- Following the inspection the registered manager told us they had introduced non appointment days on which they don't book visits or appointments to create quiet days.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- We received mixed feedback from relatives regarding the management of the service. Most told us they had confidence in the registered manager. Comments included, "The manager is great," "I have confidence in the manager," "Very good at communicating," and "The home is safe, well maintained, the manager is very helpful and approachable." However, one relative said, "I know the manager and have no confidence in them." Another said, "How is [person's name] in that job, they refuse to answer any questions and they won't engage." We found the registered manager was approachable and fully engaged in the inspection process.
- Systems were either not in place or undertaken robustly to identify and monitor the quality of the service and effectively drive improvements. This meant systems operated by the provider had failed to identify concerns and shortfalls we found during this inspection and could not be relied upon as a source to measure quality and risk. Issues included concerns with regards to safeguarding, the management of risk, management of medicines, staffing, induction and MCA.
- The service did not have an effective system in place to review staff practice and learn lessons.
- Records showed accidents and incidents were recorded, however, systems were not in place to analyse and identify any patterns or trends. This meant the provider could not be assured sufficient action had been taken to mitigate those risks, keep people safe and/or prevent/reduce re-occurrence.
- Some care records were not always accurate and had not always been updated to reflect changes in people's needs or the action staff had taken.
- Governance systems had failed to identify that CCTV was not being used in accordance with the services policy and best practice guidance.

Robust systems and processes were not in place to demonstrate the provider had effective oversight of the service. This demonstrates a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems had not been effectively established or operated to identify and report significant events. This had led to the provider not notifying the Care Quality Commission of nine significant events, which had occurred in line with their legal responsibilities.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people.

- People mostly told us they were happy living at the service and staff treated them in a kind and friendly way and they were able to choose how and where to spend their time. Comments included. Staff are really kind, Yes, I do what I want" "Staff are all lovely" and I'm taken out in the car, to my old home and shops." However, one person said, they [meaning staff] say things and don't deliver. Staff don't respect my privacy in my room, just knock and come straight in."
- During the inspection we observed some practice which did not always demonstrate a person-centred approach and was not in keeping with best practice guidance. We discussed what we found with the registered manager who provided assurance they would address these issues directly and described the plan in place to address any concerns with staff through training, and supervision.

We have recommended within the effective section of this report that the provider reviews the impact of staff training to ensure it remains effective in promoting person centred care that ensures people's dignity is promoted at all times.

Continuous learning and improving care

- Throughout the inspection, the registered manager and providers were open with us, acknowledged any areas for improvement and were keen to put processes in place to address any areas of concern or improve practice. For example, we saw the provider had recognised the management structure needed to be strengthened following the opening of a new service and had developed a management plan. This identified particular areas that needed additional focus such as, compliance, staff welfare, learning and development and activities.
- We saw that many of these changes had already been made or were in the process of taking place. The registered manager said, "Like any service we are learning all the time and we have recognised that we need to adapt and strengthen ways of working." One of the providers said, "The pandemic has taken its toll on all services. One of the things we have missed and welcomed were the regular meetings with the local authority. We found them valuable as they allowed information to be discussed in an open, transparent and timely way."
- Regular meetings and handovers at all levels helped to ensure learning was shared.

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 manager was aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm.
- The management team shared information with external agencies such as healthcare professional's when things had gone wrong as well as liaising with families.
- People and their relatives told us they were aware of how to make a complaint and felt able to raise concerns if something was not right.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, relatives and staff were encouraged to share their views and could speak to the registered manager or provider if they needed to. One relative said, "We have regular meetings, which is very helpful." However, one relative, said they did not always feel their concerns had been taken seriously or that improvements had been made when issues had been highlighted.
- There were a variety of ways in which people could provide feedback on the service. These included annual surveys, face to face meetings or over the phone.
- The provider and senior staff had mostly (see safe and effective section of this report) had good working relationships with partner agencies which helped to promote good outcomes for people. This included

working with people, their relatives, commissioners as well as other health and social care professionals.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not been identified or mitigated. People's medicines were not always managed safely. Regulation 12(1)(2)(a)(b)(g)
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 operate an effective system to investigate and report allegations of abuse.

Regulation 13 (1)(2)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not have an effective system in place to assess, monitor and improve the safety and quality of the service.

Regulation 17 (1)(2)(a)(b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to provide adequate support and training.

The provider failed provide sufficient numbers of staff to meet people's care and treatment needs.

Regulation 18 (1)(2)