Prime Care (GB) Limited

Marina Care Home

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

Summary of findings

Overall summary

About the service
Marina Care Home provides accommodation and personal care for up to 33 people. There were 13 people living in the home, some who were living with dementia. The building is a large adapted house with four floors and lift access to all floors. The top floor was closed at the time of inspection pending repairs and refurbishment.

People's experience of using this service and what we found
The management, administration and storage of medicines was unsafe. Risk management was not consistently achieved to protect people from avoidable harm, such as the storage of food thickeners. Not all staff knew how to safely support people if they had to leave the home in an emergency.

Some people's privacy and dignity was not consistently maintained. Governance systems were not always robust and operated effectively to ensure all regulatory requirements had been fulfilled. Some audits were not consistently completed and failed to either identify concerns or drive improvement.

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 but were not always followed by the provider in line with the Mental Capacity Act.

Agency staff received their induction part way through their shift. We have made a recommendation about this. While staff had knowledge on people's support needs this was not always reflected in the care plans. We have made a recommendation about this.

The top floor was closed for refurbishment. Improvements could be seen in the cleanliness and homeliness of the communal areas. Observations showed people were happy and relaxed in the company of staff. Recruitment processes had been reviewed and were more robust. People were supported to have access to healthcare professionals. People spoke positively about the food and their nutritional needs and preferences were met. Staff spoke positively about the support they received from the management team.

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 04 November 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 some regulations.

At our last inspection we recommended the provider included all relevant information in staff recruitment records. At this inspection we found the provider had introduced more robust systems and had made improvements to their recruitment processes.

This service has been in Special Measures since 04 November 2022. During this inspection the provider demonstrated that some improvements have been made. However, Marina Care Home has been rated inadequate for a second consecutive time in the well-led domain. Therefore, this service remains in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last 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.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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 Marina Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk management, working in accordance with the Mental Capacity Act 2005 and consistently promoting people's privacy and dignity. We identified a breach in relation to the ongoing failure to have effective and consistent governance of the service at this inspection.

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 overall rating for this service is 'requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'inadequate' in any Key Question over two 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 of the provider's 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 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**

Marina Care Home

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
Two inspectors, a pharmacist specialist and an Expert by Experience carried out the inspection. 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
Marina Care Home is a 'care home' without nursing. 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. 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. There was a manager in post who had yet to register with us but was unavailable during the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and 2 relatives about their experience of the care provided. We spoke with 14 members of staff including the provider, acting manager, senior care management, senior care support, carers, senior carers and night staff. We spoke with the chef, housekeeping staff, agency staff, maintenance staff and the finance controller. We had a walk around the home to make sure it was homely, suitable and safe. We observed the care and support people received. This helped us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 6 staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures were reviewed.

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

At our last inspection we found evidence people were at risk of avoidable harm. 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.

● Not all staff understood the procedures should people need to leave the home quickly in an emergency. This was a concern noted at our last inspection. The issue was dealt with on the day of inspection.
● One fire door did not close properly when released. One fire door was pushed back and wedged open on the uneven floor. This was a concern noted at our last inspection. The issue was dealt with on the day of inspection.
● Prescribed food and fluid thickeners were not stored or administered safely. Two people were prescribed the thickener and it was stored in an unlocked cupboard that was accessible to people who lived at the home. Staff did not always follow the correct instructions to ensure people received their fluids at the correct consistency. This placed people at risk of aspiration which causes problems in people's lungs.
● Two people who required or preferred a blended diet were served biscuits daily. The management team told us they would investigate this and ensure people were safe.
● The provider did not ensure all care plans had strategies to guide staff on how to keep people safe when they became distressed and what to do and say to reduce or ease their distress.

The provider failed to assess all risks to the health and safety of people receiving support with their care. They did not do all that was reasonably practicable to lessen known risks. This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to have enough trained and competent staff to administer medicines. Reviews of protocols for 'as and when' required medicines had not been completed. 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

● The management of controlled drugs was unsafe. Controlled drugs are drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful.
● People did not have 'when required' care plans to guide staff on when a when required medicine should be used.
● The temperature of the medicine fridge was above the recommended temperature range and we could not be sure the medicines were safe to use.
● The administration of medicines was unsafe. One person told us they had been left to take their tablets without supervision, had dropped one tablet and asked us for help to find it on the dining room floor. On finding it the person asked if they could then have it so they could take it. The lack of supervision placed people at risk of missing prescribed medicines. It placed people at risk of infection if they swallow tablets that have been on the floor and may have been in contact with bacteria. It placed other people at risk if they found the tablet and chose to swallow medication that was not prescribed for them.

Systems were not robust enough to ensure the safe management and administration of medicines. This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Preventing and controlling infection

At our last inspection we found systems were either not in place or not robust enough to protect people from the risk of infection. This was a breach of regulation 12(1) 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 12.

● We were somewhat assured that the provider was using PPE effectively and safely. Staff told us they had received training on the use of PPE. We noted one staff member did not have a mask on when we arrived but wore one afterwards.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Furniture had been cleaned, bathrooms and handrails were clean. New housekeeping staff had been employed since the last inspection. There were still areas of the home that had been identified as requiring updating.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. People had been supported to have their flu and COVID-19 vaccinations.
● We were assured that the provider was responding effectively to risks and signs of infection. Marina Care Home had a food hygiene rating of 5. This meant the hygiene standards were very good when they were inspected. We saw evidence that health professionals were contacted when people showed signs of infection or being unwell.
● We were assured that the provider was preventing visitors from catching and spreading infections. PPE was available to visitors at the entrance of the home.
● The provider was supporting visits for people living in the home in accordance with the current guidance. We spoke with one relative who confirmed they were able to visit when they wanted and felt safe doing so.

Staffing and recruitment

At our last inspection we found not enough suitably qualified and competent staff had been deployed to

provide safe care. This was a breach of regulation 18(1) 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.

● Systems were in place to ensure staff were recruited safely. Records confirmed a range of checks including references, disclosure and barring service (DBS) checks had been requested and obtained prior to new staff commencing work in the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, not all records held a full employment history. The provider made changes to ensure processes were in place to promote robust recruitment practices in the future.
● The provider ensured appropriate staffing arrangements were in place to meet people's assessed needs. They maintained staffing levels by using agency staff to cover vacant posts. Agency staff received an induction to familiarise them with the home and people's needs.

Learning lessons when things go wrong

At our last inspection we found opportunities to learn lessons from incidents had been missed. Not all incidents, including those where people received injuries during moving and handling, had been fully reviewed to avoid reoccurrence. This was a breach of regulation 13(1) 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 13.

● Incidents were reviewed by the management team, so risks could be lessened and action could be taken to minimise the likelihood of the accident or incident reoccurring.
● The provider demonstrated they had learned lessons since the last inspection. However, not enough improvement had been made and they were still not meeting all regulatory requirements.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found examples of neglect and people were at risk of avoidable harm. This was a breach of regulation 13(1) 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 13.

● People told us they felt safe at Marina Care Home. One person when asked said, "O aye cock, they're very good to me here." Staff told us they had received relevant training and knew how to recognise potential abuse and report any concerns. Staff said they felt able to challenge poor practice and report any concerns to a manager.

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 our last inspection the provider was not compliant with DoLS. This was a breach of regulation 11(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 11.

● The provider failed to consistently act in accordance with the principles and codes of practice associated with the Mental Capacity Act 2005. Three people had restrictions in place to keep them safe. However, the provider had failed to complete best interest decisions in relation to the use of sensor mats and not everyone who needed a DoLS authorisation had one.

The provider failed to consistently act in accordance with the principles and codes of practice associated with the Mental Capacity Act 2005. This was a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection we found systems were not in place or robust enough to ensure staff had the skills and

knowledge necessary to provide safe effective care. This was a breach of regulation 18 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.

● The provider was reliant on agency staff. We observed agency staff received induction and information sheets on people's needs. However, this was part way through their shift.

We recommend the provider introduce systems to ensure information is shared with agency staff at the start of their shift.

● There were suitably trained staff on each shift to provide support and administer medicines.
● Staff spoke positively about the support they had received from management. One staff member commented, "[Acting manager] is a really nice guy. Very approachable." A second staff member said, "I am really positive about the management team."

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

At our last inspection we found systems were not in place or robust enough to ensure people received enough to eat and drink or at the correct texture. This was a breach of regulation 14(1) 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 14.

● People were offered drinks regularly throughout the day.
● People were supported to maintain a balanced diet. Food was prepared and presented in an appropriate way. However, one person complained their lunch was too hot. Staff dealt with this immediately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At our last inspection we found some people experienced harm and the risk of harm because there was no system in place to ensure staff could access care assessments and care plans. This was a breach of Regulation 12 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 12.

● People's needs had been assessed and care plans developed to guide staff how to support people. However, two people's care plans did not have information on how to support them when they were distressed. The provider and deputy operations manager stated they would review the care plans to ensure theses guided staff on how to support them effectively.
● The provider and staff worked in partnership with social and health professionals to ensure improvements were made to the support delivered and people received suitable medical support.

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

● There had been improvements to the premises since our previous inspections. Action had been taken to make Marina Care Home cleaner and cosier.

● There were still some areas of the home which required attention. The provider had closed the top floor of the care home as they said repairs and refurbishment were scheduled to take place.

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 requires improvement. The rating for this key question has remained 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

At our last inspection people's dignity and independence was not always promoted and protected. This was a breach of regulation 10(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 10.

● The provider failed to ensure people's privacy and dignity was consistently maintained when receiving personal care. One person received a wet shave in the busy communal lounge.
● Without our intervention, one person would have received treatment from visiting health professionals in an area of the home that was visible to people and visitors in the communal area.

The provider failed to ensure when people received care and treatment, they were treated with respect and dignity and their privacy was maintained at all times. This was a continuing breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Contracted staff demonstrated a good understanding of people's needs and respected their preferences such as how they liked to spend their day and their lifestyle choices. We observed staff being compassionate and patient when people were upset. One person said, "[Staff member], she's so kind to me." One staff member told us, "I'm not here to make the staff job easier. I am here to make people happier."
● People received person-centred support. We observed staff positively engaged with people in a manner that promoted their self-esteem and included them in the daily activities and conversations within the home. We observed staff making time to share tasks with people and making them feel valued. One relative told us, "They [staff] have become part of [relative's] family, and part of our family."
● People's communication needs had been assessed and their preferred communication methods recorded in care records.

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 requires improvement. The rating for this key question has remained 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; 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

At our last inspection we found the provider had not always responded to people's changing needs. This was a breach of regulation 9(1) 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 9.

● Care records were being regularly reviewed. They included information about people's life history, experiences, hobbies and interests.
● Some care plans did not have all the relevant information required to safeguard that all staff were aware of people's unique support needs. Staff knew how to respond to meet people's individual needs.

We recommend the provider reviews all care plans to ensure they have all the relevant information to support person-centred care.

● People were supported to maintain relationships with family. One person told us their family member had been invited to have lunch with them on Christmas Day and New Year's Day.
● The home had an open-door policy on visiting. Relatives and friends were able to visit people whenever they wished. One relative told us, "I can visit anytime, I don't need to let them [management] know I am coming."
● The home was participating in Christmas jumper day when we visited. People and staff had dressed appropriately and were singing and dancing together.

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.

● People's communication needs had been recorded and information about how to support people to

communicate was included in care plans.
● Staff were seen to adapt their approach depending on who they were supporting to ensure positive communication was taking place. We observed staff giving people time to respond using their preferred names and crouching down so at eye level to promote valued conversations.

Improving care quality in response to complaints or concerns
● A complaints policy was in place. Staff expressed confidence that they could raise any issues or concerns the management team and these would be addressed.

End of life care and support
● With the support of community based health professionals, the service was able to provide care to people at the end of their life if needed. The acting manager was able to tell us what support people may require and where to access professional support and from whom.

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. 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

At our last two inspections we found systems were not robust enough to demonstrate leadership and quality assurance had been effectively managed. This was a breach of regulation 17(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 17.

● The provider failed to follow their own governance policies and failed to maintain necessary records to improve the quality and safety of people's lives. The management of medicines was unsafe, due to a lack of oversight, poor and inconsistent record keeping. Without robust checks, the provider could not always identify where improvements were required, for them to take timely action.
● The provider's checks were not effective in identifying and driving improvements. The reviews and quality assurance processes that had taken place did not always indicate improvements were required. When care plans and PEEPS needed updating or additional information was required, the review process had not recorded any shortfalls. When restrictions were in place to keep people safe, auditing processes had not identified when the provider had failed to work in accordance with the MCA 2005.

We found no evidence that people had been harmed, however the provider did not consistently and effectively operate systems to assess and monitor the service, mitigate risk and drive improvement. They did not have accurate, complete and contemporaneous records for each person and for the management of the regulated activity. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● This location has a condition of registration that it must have a registered manager. At the time of inspection, no manager was registered. The provider had recruited a new manager, but they were unavailable during the inspection.

Continuous learning and improving care; Working in partnership with others
● The provider, management team and staff had welcomed the support, guidance and oversight from the local authority. This had included restrictions on new admissions to the home and several people moving to

more suitable locations that could meet their needs.
● The provider had introduced new ways of working to drive improvement. We were unable to say if new processes were embedded and would be sustained as the provider was still in the process of reviewing their systems.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had participated in a relative's meeting to discuss previous concerns identified by ourselves and the local authority.
● Staff praised the support they had received from the acting manager and management team. One staff member commented, "I have picked the best home to work at. They [management] have supported me really well." A second staff member said, "We are on the up here now. [Management] have been really good to me." A third staff member told us, "[Acting manager] he's really hands on and very understanding, all the residents love him. The management, they listen to us."
● There was a good approach to teamwork within the home. This could be observed through interactions and staff working together on the day of the inspection. There was a lot of laughter throughout the home between people and the staff.
● The manager had daily handover meetings for staff when shifts changed. This allowed staff to be updated on relevant information related to the care and support requirements of people.

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 management team were aware of their responsibilities under the 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.

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 The provider failed to ensure when people received care and treatment, they were treated with respect and dignity and their privacy was maintained at all times. 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to consistently act in accordance with the principles and code of practice associated with the Mental Capacity Act 2005 when a person lacked capacity to make an informed decision. 11(1)

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 assess all risks to the health and safety of people receiving support with their care. They did not do all that was reasonably practicable to lessen known risks. Systems were not robust enough to ensure the safe management and administration of medicines. 12(1)(2)(a)(b)(g)

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 We found no evidence that people had been harmed however the provider did not consistently and effectively operate established systems to assess and monitor the service, mitigate risk and drive improvement. They did not have accurate, complete and contemporaneous records for each person and for the management of the regulated activity. 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

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