Valley View Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Valley View Care Home Ltd is a residential care home providing personal and nursing care to 26 people aged 65 and over at the time of the inspection. The service has two floors and is purpose built. The service can support up to 33 people.

People's experience of using this service and what we found
People told us they were happy living at Valley View Care Home. Relatives told us, "I would recommend Valley View because the staff are friendly, and they will take time out with mum. For example, [activities staff] sat in the garden with mum so she could have her dinner out there" and "Valley View is really, really good due to the attention to detail of the staff. They are absolutely brilliant."

Risks to people's safety had not always been identified. Risk assessments did not have all the information staff needed to keep people safe. Medicines management was poor. The provider could not be assured that people had received their medicines as prescribed.

We were not wholly assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records did not evidence that additional cleaning of high touch areas such as switches and handrails had been cleaned in line with infection control guidance. Infection control audits had not been reviewed and amended to reflect the COVID-19 pandemic.

Staff had not always been safely recruited, the provider had not ensured that each staff member had a full employment history. Pre employment checks had been carried out, such as Disclosure and Barring Service (DBS) criminal record checks and reference checks.

The service was not always well led. Records were not always robust and accurate. The provider had failed to identify issues relating to risk assessments, staff recruitment, medicines management and records we had identified. Registered persons had not always notified us of incidents relating to the service. These notifications tell us about any important events that had happened in the service.

Assessments of staffing levels were undertaken by the registered manager. However, it was not clear how the data collected informed the staffing rota. Most staff said there was not enough staff in the mornings to meet people's needs which included ensuring people had time to engage and participate in meaningful activities. We made a recommendation about this.

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.

Staff understood their responsibilities to protect people from abuse. Staff described what abuse meant and told us how they would respond and report if they witnessed anything untoward.

People were treated with dignity and respect. People's views about how they preferred to receive their care were listened to and respected. People and relatives told us staff were kind and caring.

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

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 December 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 17 October 2019. Breaches of legal requirements were found in relation to safe care and treatment, dignity and respect and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Caring and Well-led which contain those requirements.

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 ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Valley View Care Home Ltd on our website at www.cqc.org.uk.

Enforcement
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 to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, management of medicines, infection prevention and control, safe recruitment practice, good governance and notifying CQC of incidents that had occurred.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Valley View Care Home Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Valley View Care Home Ltd 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We took this into account when we inspected the service and made the judgements in this

report.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they did not have any information about the service. We used all of this information to plan our inspection.

During the inspection
Some people were not able to verbally express their experiences of staying at the service. We observed staff interactions with people and observed care and support in communal areas. We spent time speaking with four people, six relatives and one person's friend.

We spoke with seven staff including; the care staff, senior care staff, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. This included speaking with staff in person on the day of the inspection and by telephone after the inspection.

We reviewed a range of records. This included five people's personal care records, care plans and people's medicines charts, risk assessments, staff rotas, staff schedules, two staff recruitment records, and meeting minutes. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and quality assurance records.

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 the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

At our last inspection, the provider failed to take appropriate actions to ensure medicines were managed in a safe way. This was a continued breach of Regulation 12 (Safe Care and Treatment) 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

● At the last inspection, medicines in stock did not balance with the medicines administration records (MAR) and stock sheets. At this inspection, we found the same concerns, medicines for some people did not balance. One person's Paracetamol did not balance with the records and another person's Risperidone did not balance with the records.
● At the last inspection, one person's MAR detailed that staff should apply a medicated pain patch every three days to the person. The person's pain patch record did not always show that the pain patch had been re sited on different areas of the body to reduce the risk of skin irritation. At this inspection, we found that one person's pain patch record had not been completed to evidence where their pain patch had been sited. Another person's pain patch records evidenced that a pain patch had been applied to the same site as it had previously which increased the risks of the person's skin becoming irritated. After the inspection the registered manager investigated this and found that the patch had been applied to a different site but identified there had been a recording error.
● Protocols were in place for most people to detail how they communicated pain, why they needed as and when required medicines and what the maximum dosages were. However, some people did not have PRN protocols in place. Two people did not have protocols in place in relation to their pain relief. One person did not have protocols in place in relation to their eye drops and laxative. Staff (including those administering these medicines) may not have all the information they need about people's PRN medicines.
● Prescribed medicines had not always been stored securely. During the inspection we found a large stock of prescribed nutritional drinks stored in a hallway. Registered persons told us these were waiting to be collected by the pharmacy. These should have been stored securely to prevent unauthorised access.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● At the last inspection, the process for medicines for disposal and return was not robust. At this inspection, this had improved. The provider had more robust systems in place in relation to the disposal and returns of spoilt and unwanted medicines.

Assessing risk, safety monitoring and management

● At our last inspection, fire safety risks had not always been assessed and well managed. We found moving and handling equipment such as hoists and stand aids stored in the corridors on both floors on both days of the inspection. This restricted the width of the corridors which would hinder evacuation using emergency evacuation equipment if there was a fire. At this inspection, corridors were free of equipment which could restrict safe evacuation. However, fire risks remained. Fire alarm test records showed that the fire alarm had not been tested since 24 May 2021, this should have been tested weekly. Portable appliance testing (PAT) on electrical equipment had not taken place. Some new staff have not been added to fire drill matrix. Some staff we spoke with have not been involved in a fire drill within 12 months. This increased the risk to people. After the inspection, the provider confirmed that the fire alarm had not been tested due to a communication breakdown between a contractor who had diagnosed a fault and the service. They assured us this had been resolved and the fire alarm was working. The provider also confirmed electrical equipment had been PAT tested.

● Risk assessments did not always provide clear guidance to staff about how to meet people's needs safely. Risks around constipation were not always clear for staff around when to report if a person had not opened their bowels. The risk assessments did not provide guidance to staff at what stage to administer the laxative medicine. For example, describing how long in days or hours the person had last opened their bowels or how to recognise how the person showed signs they were constipated. This put people at risk of pain and discomfort from constipation. After the inspection the registered managed told us they had started to complete the risk assessments for those who suffer with constipation that are prescribed laxatives.

● Some people were at risk of not taking their medicines as prescribed because they were left their medicines to take at a later time. There were no risk assessments in place regarding this and care plans for people stated 'observe [person] whilst she takes her tablets'.

● One person had been assessed as a high ligature risk from their call bell and lead, so they did not have one in reach. There was no risk assessment in place to describe the risks and measure to mitigate the risks to keep the person safe. Although staff we spoke with knew that the person must not have the call bell in reach for their own safety, new staff or agency would not necessarily know as it was not documented in the care plan or risk assessments.

● Risk assessments regarding skin integrity had not always been followed. Repositioning charts did not always show that people had been repositioned in the timescales detailed in the care plan and risk assessment. This put people at risk of pressure damage.

● There were no risk assessments in place to for people on blood thinning medicines that were at risk of falls, increased risk of bleeding, bruising. This meant that staff did not have all the information they needed to provide safe care. After the inspection the registered managed told us they had started to complete the risk assessments for blood thinning medicines.

The failure to ensure risks were robustly identified and managed to prevent harm so people received safe care and the failure to consistently monitor incidents to learn lessons and mitigate individual risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records did not evidence that additional cleaning of high touch areas such as switches and handrails had been cleaned in line with infection control guidance. Infection control audits

had not been reviewed and amended to reflect the COVID-19 pandemic.
● We were not assured that the provider was preventing transmission of infection and/or managing outbreaks through staff training, practices and deployment. The registered manager told us staff only worked at the service. However, we observed a staff member working at the service who worked at one of the provider's other services. The provider told us that this was to help out due to short notice absence.

The failure to ensure effective and robust infection control practices are in place to provide safe care is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Staffing and recruitment
● Staff had not always been recruited safely to ensure they were suitable to work with people. The provider had not always carried out checks to explore staff members' employment history. We reviewed two recruitment files for staff who had been employed since the last inspection. Both staff application forms had gaps in the employment history that had not been accounted for. Interview records did not evidence that this had been identified and discussed.

The failure to ensure staff were recruited safely is a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider continued to ensure staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their PIN numbers to confirm their registration status.

● Assessments of staffing levels were undertaken by the registered manager. However, it was not clear how the data collected informed the staffing rota. Most staff said there was not enough staff with four staff working upstairs and two working downstairs in the mornings to meet people's needs which included ensuring people had time to engage and participate. Staff explained that the staff member coordinating activities was often diverted to carry out visitor COVID-19 testing which took time for activities including one to one contact away from people. Relatives echoed this feedback stating that staff were often rushed.
● Relatives comments included, "I get the feeling staff are whacked out and so they tend to use a lot of agency staff. I don't think staff have time to chat to mum"; "I know sometimes they are a bit stressed, which means [loved one] sometimes might have to wait a little while before they answer her bell"; "Staff don't have any time to spend with the clients at all"; "Some carers have been caring but it's so busy. The girls are run off their feet trying to keep everyone separate so there's no contamination."

We recommend the provider seeks advice from a reputable source, to suitably assess the numbers of staff needed to meet people's needs, to aid the deployment of staff.

● People told us their call bells were mostly answered quickly. One person said, "I only use the call bell if I need it." Another person said, "I can buzz them and they come in. I don't like lying here when I'm awake. Sometimes I buzz them (to get up) but they don't come." We observed call bells were answered quickly.

Learning lessons when things go wrong
● The provider continued to have a system in place to monitor accidents and incidents, learning lessons from these to reduce the risks of issues occurring again.
● Records evidenced where follow up action had been taken after the accident or incident. This included who had been notified of the incident and whether support plans and risk assessments had been updated.
● The registered manager had followed up incidents and accidents. Incidents and accidents continued to be reported to the provider. The registered manager had made referrals to appropriate professionals such as falls prevention practitioners when people had frequently fallen.

Systems and processes to safeguard people from the risk of abuse
● Staff continued to understand their responsibilities to protect people from abuse. They had received training to make sure they had the information they needed to keep people safe. Staff described what abuse meant and told us how they would respond and report if they witnessed anything untoward. A person told us, "I've always felt safe here."
● Staff told us the management team were approachable and always listened and acted where necessary, so they would have no hesitation in raising any concerns they had. Staff felt sure action would be taken straight away. Staff knew how to raise and report concerns outside of their organisation if necessary.
● Staff said, "I would report abuse to [registered manager] or the senior nurse, I would think it would be dealt with, could speak to [nominated individual] or the council" and "I have done safeguarding, I would alert/inform the nurse in charge of allegations of abuse, document it, they would have to act"
● Where safeguarding concerns had been received, appropriate action had been taken to address these.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now improved to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At our last inspection, the provider had failed to treat people with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection, the provider had made improvements and was not longer in breach of regulation 10.

● At the last inspection, people did not always feel listened to. At this inspection, we observed people being listened to. One person reported to staff their television would not change channels. Two staff members spent time trying to rectify the issue and explained they were unable to. They advised the person they would report it and the maintenance person would call in to fix in the next day. The person was happy with this as the channel the television was stuck on was the channel showing the football.
● At the last inspection, some people felt their dignity had not been upheld. Two people who had lived at the service for more than four weeks had not been offered or supported to have a bath or shower. At this inspection, people told us they received baths and showers to meet their needs. One person said, "I had my hair done yesterday. I prefer a strip wash in bed." Another person told, "I wash every day and am happy about this, I was told by my Doctor not to have a shower at the moment, I might slip." Another person said, "Friday is my shower day. It nearly always happens. Usually they wash me in bed." A relative told us, "Mum loved having her nails done (pre COVID-19). During lockdown, staff really put themselves out by maintaining them for her, [left them long and painted them.]"
● At the last inspection, one person told us their dignity was not respected because some staff had poor personal hygiene which had impacted on their enjoyment of their food. At this inspection, people and staff told us this had been resolved and not happened since.
● At the last inspection, one person explained they had an undignified response by a staff member when they had requested help and support in the night to use the toilet. At this inspection, we did not receive negative comments about being supported to use the toilet. We observed people being supported discreetly and appropriately.
● People and relatives told us their choices were respected. One relative said, "Mum is very conscious of fashion. The staff are very accommodating and get several choices of clothes out for her." Another relative said, "It's always mum's decision not to go to the dining room or church services."
● We observed staff supporting people to make everyday choices such as, whether to participate in

activities, be in communal areas or their own room, what clothes they wished to wear, what television channels they wished to watch and what drinks and food they would like. On the day of the inspection, people were having a fish and chip lunch from a local fish and chip lunch, people were given choices about whether they wanted this meal or a home cooked alternative. Those that had the fish and chip meal chose whether to eat it from the box, on a plate, with cutlery or using their fingers.

● People's records continued to be stored securely to protect their privacy.

● People told us they were happy and liked the staff. One person said, "The girls are lovely, I can't fault them." We observed people interacting with staff and smiling. Where people had difficulty expressing their needs verbally, staff took time to listen and used cards and pictures to support people to communicate their needs. A relative told us, "I think the care's top class. [Loved one] always looks very clean and well cared for. She is so relaxed and happy there."

Ensuring people are well treated and supported; respecting equality and diversity

● We observed staff treating people with dignity and respect. People's rooms were closed when people were being supported with their personal care. A light above the door indicated to others that personal care was being provided to prevent others from entering the room and compromising people's privacy and dignity.

● Staff were seen to be kind and caring and used people's preferred names. Staff offered reassurance when needed and were discreet in checking with people about support to utilise the toilet, particularly in communal areas.

● People we spoke with gave positive feedback about their care and the staff. Comments included, "I could not be better cared for and attention, they couldn't be nicer people"; "I get on very well with staff" and "Some carers are better than others, on the whole they are very good."

● Relatives said, "Mum actually calls it her home. She loves the staff and knows all their names. They all pop in to see her and they come to say hello to us when we're visiting"; "There's always a lovely reception when I visit. It's a lovely atmosphere. I wouldn't mind going there myself"; "[loved one] has had a vicar come in to see her, but I'm not sure if there are any services going on" and "I think she's well looked after and seems content there."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

● At the last inspection, the systems to review and check the quality of the service were not always robust and timely action had not always taken place to address issues found. At this inspection, the systems in place to audit the quality of the service continued not to be robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up shortfalls in practices in relation to risk assessment, fire safety, medicines management and safe recruitment practice.
● At the last inspection we raised that there was a lack of management oversight and management action at the service because the registered manager had spent more than half of their time working as a registered nurse as part of the care team. At this inspection, the registered manager remained rostered to work on shift as part of the care team for majority of their contracted hours. The registered manager had covered another registered nurses' long-term sick leave. This had diverted the registered manager from effectively managing the service. We reported to the provider that we remained concerned that this practice continued despite this being raised with them at the previous two inspections.
● Monthly audits had not always taken place. A wound audit had not been completed since 30 April 2021. An audit checklist completed on 01 June 2021 stated that all audits including wound audits had been completed. This conflicted with the information we found.
● Some staff told us there was a poor culture within the service and made allegations of bullying within the staff team. Some staff did not feel confident in a senior staff members skills, abilities and communication skills. We reported this to the registered manager and provider who agreed to look into it.
● Records were an area of concern. Records were not always complete, accurate or contemporaneous. Some people's oral care has not been documented, within the daily notes or on the separate tick box on the care charts. Some staff had recorded one person's call bell was in reach, however the person does not have a call bell because they lacked capacity to use one and the call bell lead was a risk to the person.

Registered persons have failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● At the last inspection, registered persons had not always notified us of specific incidents relating to the service in a timely manner. These notifications tell us about any important events that had happened in the service. At this inspection we found the same. CQC had not been notified of a serious injury which had occurred in May 2021. The registered manager explained that initially the person was checked by the hospital following a fall and no fracture was found, then the hospital made contact to say there was a fracture.

The failure to notify CQC of incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The last inspection rating was prominently displayed at the main entrance, as well as being displayed on their website.
● There continued to be a range of policies and procedures available to staff governing how the service needed to be run. These were regularly reviewed and updated.

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

● Compliments had been received. These included, 'May I take this opportunity to thank you and all at Valley View Care Home for looking after mum with your kind and tender care'; 'To everyone who looked after [person], I would just like to express my gratitude for the constant care and attention you gave to her wellbeing and safety, thank you' and 'Thank you for the care and love you gave to mum over the past couple of years'
● Relatives gave us mixed feedback about communication and whether they'd been asked for feedback. Comments included, "If I have any concerns, they deal with them straight away and always communicate with me"; "If I have any issues, I generally ring [registered manager] up and she will try and sort it"; "They take any suggestions on board" and "I feel unable to broach management on issues because I am not sure which management is in that day."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager continued to have a good understanding of their responsibilities under the duty of candour.
● The provider and registered manager told us they were committed to ensuring that people received improved experiences and high-quality care and that lessons were learnt from this inspection and inspections in the provider's other local services.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us that they were able to share their ideas and felt listened to by the registered manager. One staff member said, "It has changed for the better since [registered manager] has been there. She is a brilliant

manager." Staff felt well supported by the registered manager.
● Staff meetings had taken place regularly. One staff member said, "Incidents and accidents are discussed at handover. We have a handover to detail what has happened on shift. We have staff meetings, there is not an agenda, however I will bring things up and will discuss things." Another staff member told us, "[Registered manager] tells us things in handover, I find her good, easy to talk to. I can go to her with problems. [Registered manager] does staff meetings, we can discuss things."
● The provider had sent out surveys to people to gain feedback about their experiences, just before the inspection, the results of the survey were still being received and analysed. The previous survey results were displayed in the hallway.
● The registered manager explained that relatives' meetings had been paused due to COVID-19 restrictions, to ensure people, staff and visitor safety. The management team planned to reinstate these in line with government guidance.
● Not everyone living at the service had been enabled to utilise video calling and the use of technology to maintain contact with their friends and relatives because of poor WIFI signals in certain areas of the service. This had meant that relatives could not maintain contact and they were unable to get in contact with others when they wanted. This could lead to isolation for a number of people. We fed back these concerns to the provider who advised they would upgrade the WIFI throughout the service to enable all people to maintain important relationships. After the inspection, the provider told us the WIFI provider had already been contacted and they were looking to install WIFI extenders going forward.

Working in partnership with others
● The service worked closely with other health and social care professionals to ensure people received consistent care and treatment.
● Most staff told us they were kept informed about engagement and outcomes with health and social care professionals that could result in a change to a person's care, for example, following a visit from the community nurse, GP or dietician.
● The registered manager has engaged with external support networks during the COVID-19 pandemic which has enabled them to keep up to date with changing guidance.

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 Registered persons had failed to notify CQC of incidents Regulation 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Registered persons had failed to ensure staff were recruited safely. Regulation 19 (1)(2)(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks were robustly identified and managed to prevent harm so people received safe care and failed to consistently monitor incidents to learn lessons and mitigate individual risks. The provider had failed to take appropriate actions to ensure medicines are managed in a safe way. The provider had failed to ensure safe infection prevention and control systems were in place. Regulation 12 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons have failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. Regulation 17 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration