Mills Family Limited

# Fairlight & Fallowfield

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Good |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

About the service
Fairlight and Fallowfield is a care home made up of two units, a nursing unit and a residential unit in adjoining buildings; Fairlight is the residential unit and Fallowfield the nursing unit. The care home accommodates up to 55 people in total. There were 40 people aged 65 and over living there at the time of the inspection.

People's experience of using this service and what we found
Supplementary records of people's care showed people were not consistently being checked in relation to repositioning, hourly checks and fluid intake. Call bell risk assessments were not in place for people who lacked capacity. Some aspects of medicines were not managed safely. There was no record of the checking of expiry dates and the same medicines for different people was being stored together. There were instances where people were not treated with respect and privacy ensured. Care plans lacked detail on how people should be supported appropriately. There were systems in place to assess and monitor the quality of the service provided. However, these were not always effective and did not identify the shortfalls found during this inspection.

We have made a recommendation about care planning guidance in relation to supporting people's needs.

The service had safeguarding procedures in place and staff had a clear understanding of these procedures. Appropriate recruitment checks had taken place before staff started work and there were enough staff available to meet people's care and support needs. The service had procedures in place to reduce the risk of infections. Accident and incidents were recorded and acted upon. Any lessons learnt were used as opportunities to improve the quality of service.

People's care and support needs were assessed when they moved into the home. Staff were supported through training, regular supervision and annual appraisals of their work performance. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's independence was promoted. People and their relatives had been were involved in decisions about their care.

People were supported to maintain relationships and engage in activities they enjoyed. The home had a complaints procedure in place. People were supported to make decisions about their preferences and choices for their end of life care.

The manager and staff worked in partnership with health and social care providers to plan and deliver an effective service. The service took the views of people and their relatives into account through meetings and care review meetings.

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 24 June 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last eight consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, dignity and respect, and good governance.

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 for 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 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?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Good

The service was effective.

Details are in our effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

# Fairlight & Fallowfield

**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.

Inspection team
The inspection team consisted of two inspectors, an inspection manager, a medicines inspector, a nursing specialist adviser and two experts by experiences. 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
Fairlight and Fallowfield is a care home that provides accommodation and personal care for older adults. People in care homes receive accommodation and nursing or personal care as 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 in place however they were not yet registered with the Care Quality Commission. A registered manager 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
The inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service. This included details about incidents the provider must notify us about, such as allegations of abuse, and accident and incidents. 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 used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives to gain their views about the service. We spoke with four staff members, the manager, residential manager, head of activities, director of care and the provider.

We reviewed a range of records. This included nine people's care plans, risk assessments and medicine records. We looked at six staff files in relation to recruitment, training and supervision. We also looked at records relating to the management of the service such as audits and a variety of policies and procedures developed and implemented by the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at risk assessments 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.

Assessing risk, safety monitoring and management

At the last inspection on 8 and January 2019, we found the provider failed to identify and assess some risks to people' safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

• Supplementary records for people using the service showed multiple discrepancies, therefore we could not be assured that people received safe care. Records showed people at risk of developing pressure ulcers were not being repositioned as required and hourly checks to ensure people's safety were not being completed. For example, a person needed to repositioned hourly, however records showed on 11/3/2020, the person was repositioned at 9.07am and then 11.41am. Another person needed to be checked hourly, however on 7/3/2020, records showed the person was checked at 11.32am and then 18.09pm.
• Records showed for a person who had significant continence issues and required hourly checks were not carried out which placed them at risk of poor hygiene. For example, on 6/3/2020 records show the person was checked at 20.01pm and then 23:21pm.
• People's fluid intake had not been consistently documented. For example, a person needed to be offered a drink every hour and ensure they consumed 500ml in 24 hours. However, records showed on 5/3/20, the person only drank 345ml and was offered a drink at 09:06am, 10:43am,15:48pm and 17:24pm only.
• There were no call bell risk assessments in place for people who were not able to use a call bell due to their capacity levels.
• Staff did not follow guidance to support people safely with their food and drink. For example, the care plan and SALT guidance for a person stated the person must be 'upright and alert.' However, during lunch time, we observed the person was sat in a chair but was tilted back and appeared sleepy as staff were attempting to feed them. We raised this with the director of care who ensured the person was repositioned and seated upright.
• A person on a soft diet was to avoid specially prepared biscuits, however we found a plate of biscuits in their room. Another person on a pureed diet, we found boxes of sweets and chocolates in their room which they could not safely eat. We raised this with the director of care who agreed the person should not have had them in their room, and ensured these were removed.

We could not be assured that people consistently received safe care and treatment. This is a continued

breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other risks to people had been identified and assessed. Risk assessments were in place detailing guidance to prevent or reduce the risk of people being harmed which covered areas including personal care, choking, mobility, moving and handling and for people who were at high risk of falls and liked to use the stairs. • Health and safety checks including fire safety, water temperature, electrical and gas safety checks were carried out to ensure the environment and equipment was safe for use.

Staffing and recruitment
• During the inspection, there were sufficient numbers of staff to ensure people's needs were being met. However, we received mixed feedback from people and relatives about staffing levels. A relative told us "We do feel [person] is safe here as there are a lot of staff here and they pop in on [person] as they aren't going down to the lounge or dining room as much." However, a person told us "You can buzz, and they don't come, you could wait quarter of an hour. I've had an accident whilst I've been waiting." "
• Records showed a dependency tool was being used to assess staffing levels in the home which was based on people's needs. Call bell response times were being monitored by the manager and records showed the majority of times call bells were responded to promptly.
• The provider followed safe recruitment practices and ensured all staff pre-employment checks were completed before they could work at the home. Nursing staff also had their professional registrations checked to ensure they were fit to practice.

Using medicines safely
• There were areas where medicines were not being managed safely. In the nursing unit, there was no record of the checking of expiry dates, this meant people were at risk of receiving medicines that were not safe or effective. We spoke to the nurse who told us that staff did check expiry dates, however there were no records to show that the dates had been checked. This was not in line with the provider's medicines policy which required regular expiry date checking and recording of the activity.
• In the clinical rooms for both units, medicines were individually labelled, however, there was a risk of people receiving the wrong medicines in error, as the same medicines for different people was being stored adjacently on the same shelf with no physical separation. Shortly after the inspection, the manager advised us that people's medicines were now stored separately and individually labelled.
• There were arrangements in place to manage and store medicines safely. Medicines administration records (MARs) showed people received their medicines as prescribed. There were medicines audits in place and any actions required had been undertaken. Staff had completed training to administer medicines and their competency was checked.
• People and relatives spoke positively about the support they received with their medicines. A person told us "'I am only on two tablets now and they are given to me on time."

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. People and their relatives told us they felt safe. A person told us, "I do feel safe and secure living here as they have staff and procedures they follow.' A relative told us, "I have got no reason for concerns."
• There were safeguarding and whistleblowing policies in place and staff had completed safeguarding adults training. Staff were aware of the different types of abuse and reporting procedures to follow if they had any concerns of abuse.
• Where there were concerns of abuse, the manager had notified relevant healthcare professionals, including the local authority safeguarding team and CQC.

Preventing and controlling infection

• People were protected from the spread of infection. An Infection control policy and measures were in place for infection prevention and control. Substances that could be potentially hazardous to people's health (Control of substances hazardous to health (COSHH) were locked away and kept safely away from people.
• During the inspection, we observed staff maintaining the cleanliness of the home. Staff had completed infection control training and wore protective personal protective equipment when supporting people.

Learning lessons when things go wrong
•The provider had an electronic system in place to record and respond to accidents and incidents in a timely manner. The system had triggers to ensure action was taken which included notification to relevant healthcare professionals and CQC.
•The system enabled accidents and incidents and complaints to be analysed for specific trends. Any lessons learnt were used to improve the quality of service which were relayed to care workers to embed good practice.'

Good

# 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 the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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 Act 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.

•The service was working within the principles of the MCA. Where people had capacity, records showed the service obtained their consent about their care and support. Where people lacked capacity, records showed mental capacity was assessed and the best interests decision making process has been followed which included involving relatives and healthcare professionals.
• Where people living at the home had been deprived of their liberty for their own safety, DoLS authorisations were in place and any conditions placed on them were being met and kept under review.
• People and relatives confirmed staff asked for people's consent before providing care. A person told us "I get on so well with the staff, they know what they are doing and always ask me first before they do anything." A relative told us "We have Power of Attorney and I went to previous review meeting about the care."

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported with their nutritional and hydrational needs. Kitchen staff were aware of key information relating to people's dietary requirements. Lunch time observations showed people's food was provided in accordance to their needs such as pureed and the use of thickeners where required.
• People spoke positively about the food and drink in the home. A person told us "There is always a choice of food and it's excellent and plenty of it." Another person told us "You are always asked what you would like

and if you don't fancy what's on offer an alternative is always found." However, two people did tell us that food was cold by the time it was served to them. A person told us "The food is very good here although sometimes spoilt by the fact it's not hot enough when it gets to my room." Another person told us "The food is sometimes cold when I am here and that's not very appetizing which is a shame as the food itself is very good."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments were carried out before people started using the service to ensure their needs could be met. People and relatives were involved in the assessments to enable them to make an informed choice about their care.
• During the assessments, expected outcomes for people's care were identified and were used to develop their care plans.

Staff support: induction, training, skills and experience
• Staff received the training and support they needed to effectively meet people's needs. Staff had completed an induction programme based on the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for people working in care.
• Records showed staff had completed up to date training the provider considered mandatory in areas such as health and safety, fire awareness, medicines, infection control, moving and handling and equality and diversity. Staff were supported through regular supervisions and appraisals which enabled them to discuss their personal development objectives and goals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare services when required. The service worked in partnership with other services, and health and social care professionals such as social workers, district nurses, SALT and GPs to deliver effective care.
• People and relatives spoke positively about the support they received. A person told us "The GP comes here every week, if I need to see a dentist or optician, I go out to see them accompanied either by one of my family or a member of staff." Another person told us "I have [medical condition] and the district nurse was coming every other day to dress it but now twice a week, as its improved."

Adapting service, design, decoration to meet people's needs
• We observed reasonable adjustments had been made in the home in response to people's specific needs. People had access to equipment to assist with their needs such as wheelchairs and lifts to allow easy access around the home.
• People's bedrooms were personalised with their belongings to assist people to feel at home.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• There were instances where staff were not caring, and people were not treated well. For example, during lunch time, staff kept referring to people by their room number and not by their name in front of other people. Staff said, "19 does she have juice" and "I will come and do 6." We also observed a person being wheeled into the dining room whilst still asleep.
• Staff did not explain to people what they were about to do before supporting them. For example, staff placed clothes protectors around people without informing them beforehand. We observed, particularly in the nursing unit, staff put people's food down in front of them without telling them what it was, no one was offered more or asked if they enjoyed the food.
• Staff did not respond to people's requests with empathy or provide reassurances to ensure people did not get agitated or anxious. For example, a person asked for dessert and was told they couldn't have their dessert until everyone had finished. Another person, despite asking numerous times was never transferred into a dining chair as they requested and became agitated when they had to keep asking for their lunch as they had a hairdresser's appointment which they thought, they would miss.
• There were instances in which people did not feel their privacy and dignity was not respected. We received mixed feedback from people. A person told us "'If I am in my room staff always knock before they come in." However, this person told us, "There isn't much privacy, when I came here, I realised your body was no longer your own." Another person told us "Staff don't always knock before coming into my room."

There were instances where people were not treated with respect and their privacy was not ensured. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

'• The registered manager told us they took immediate action after the inspection and have carried out mealtime observations to ensure people are supported appropriately and treated respectfully. We will follow this up at the next inspection.
• Some people and their relatives did tell us staff were kind and caring. One person told us "You can have a laugh with the staff as they are very friendly." Another person told us "Oh yes they [staff] treat me well. They pop in from time to time to see if I want anything." A relative told us staff were "All very lovely."
• Records showed the service also received written compliments from people using the service and their relatives. For example, comments from a relative included "Thank you to all the staff at Fairlight, for the excellent care, compassion and support given to [person]…..and to the kindness always shown to them."
• People's cultural and religious needs were respected and accommodated. A person told us "There is a

church service held here in the library by the vicar of St Nicholas Church, I have been to one service and enjoyed it." A relative told us "Lots of people from [person's] church have come to see them."
• People were supported with their independence and encouraged to do as much as they could for themselves. A person told us, "Staff encourage me to be independent, but assistance is there if I need it." Another person told us "I have one bath a week, they take me to the bathroom, and I do as much as I can myself."

Supporting people to express their views and be involved in making decisions about their care
• Records showed people and their relatives were involved in decisions about their care. Review meetings and a 'resident of the day' initiative took place with people using the service and relatives in which people's care was discussed and reviewed to ensure people's needs were being met effectively. A person told us "I went through it [care plan] recently with a member of staff, I also spoke about an end of life plan."
• People received information in the form of a 'service user guide' prior to joining the service. This guide detailed the standard of care people could expect and the services provided.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
• People's care plans were person centred and included details of their sexuality, cultural and religious needs. However, care plans lacked detail on how people should be supported appropriately, which placed them at risk of receiving inappropriate care. For example, for one person, the care plan stated they were prone to depression, however there was limited detail as to how the person could be supported with this.
• There was an electronic care record system in place which at times, was difficult to follow and contained either duplicated, contradictory or unclear information. For example, for one person, one section of their care plan stated, 'people using a comb or hairbrush upsets me, in another section it stated '[person] needs full assistance to brush and comb their hair'. In another section, it stated the person's relative did this for them.
• Two people had diabetes, however there was no specific diabetes care plan in place. Two people needed to use a catheter, however there were no specific care plans in place that described positioning and infection control in detail. For one of these people, the information about their catheter was integrated within the continence management plan.
• Some risk assessments and care plans had not been updated to reflect SALT guidance and contained contradictory information. For example, advice provided by SALT for a person, stated to give fluids from an open-ended cup rather than use a straw, however their care plan stated the person 'prefers to use straws.' The person also required food to be moistened with gravy/sauce and to be sitting upright for 15 minutes after eating. However, none of this information was detailed in their care plan and risk assessment.
• Pressure mattresses were not set at the correct settings to help reduce the risk of pressure sores developing. For example, the settings for two people's mattresses were set too high. For another person who was nursed on a pressure mattress, there was no information detailing the correct setting in their care plan. We raised this with the director of care who agreed the mattresses were set too high.
• A person told us "I had a problem with my heel and although it's now better its very tender, so I don't wear shoes. It was a bit confusing as different staff gave me different information about looking after it."

We recommend the provider seeks advice from a reputable source on care planning documentation which would reflect complete guidance in relation to people's needs and the support required.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's care plans contained information which showed how they communicated and whether they were able to communicate their wishes. The manager told us they were able to tailor information in accordance to people's needs and in different formats if needed.

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
• The service had an activity co-ordinator in place and people who engaged in these activities spoke positively about them. A person told us "The entertainment and outings on offer here are very good, we go out to the theatre and if I book in advance, I can go to the theatre with a carer…. it's my real passion." Another person told us, "The staff here are very good. I enjoy the activities, and they seem to care about me."
• During the inspection, we observed a range of activities taking place including gentle care exercises, a quiz, board games and a cheese and wine activity. People appeared to be engaged and enjoying the activities and there was quite a lot of positive interaction between people.
• Staff supported and encouraged people to maintain relationships with family members. Family members were able to visit at any time and spend quality time with people and in private if they wished to do so.

Improving care quality in response to complaints or concerns
• There were procedures for receiving, handling and responding to complaints. Records showed complaints had been responded to appropriately.
• People and relatives were aware of how to complain and had the confidence that any issues they raised would be addressed. A person told us "If a concern or niggle…I speak to my family and they sort it out, recently we emailed the manager as I was upset at not going out. This was rectified and I get to go out now." A relative told us "I can and do take any concerns to the residential manager. I feel listened to and eventually get the outcome I want." However, two people told us "I don't really think you are listened to if you have a complaint and the manager fobs you off." Another person told us "They are not really interested if you have a complaint."

End of life care and support
• No one at the service was receiving end of life care at the time of our inspection. However, the manager told us, should the need arise, they would work with people, family members and other healthcare professionals to ensure people's end of life wishes and care were identified, and measures put in place to ensure these were met. Staff had received end of life care training.
• People's end of life wishes were detailed in their care plans to ensure these could be met.

Requires Improvement

# 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 remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection on 8 and January 2019, we found the provider failed to effectively monitor the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

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

• The provider completed a number of audits including areas such as care plans, medicines, health and safety, quarterly night checks, call bell monitoring, cleaning and infection control. However, these had not identified the issues identified at this inspection in relation to repositioning, fluid intake and hourly checks for people, call bell risk assessments, instances in which staff were not caring and care plans lacking detail in relation to specific health conditions.
• We noted some audits had not been fully completed, therefore, we could not be assured as to the effectiveness of the audits as there were inconsistences with recording if actions had been followed up. For example, the health and safety audit and infection control audits showed actions had been followed up and documented as completed.
• However, the cleaning and care plans audits contained no information on whether actions had been followed up. Therefore, we could not be assured these had been actioned. For example, the December 2019 audit stated, 'Room 7, smell' and 'Room 9, Toilet needs a good clean,' however no further information detailing whether this had been followed up. The January 2020 audit stated, 'Shower room – Bed bumper been in there for a week' and 'Shower room – wheelchair and three cushions in there', however there was no evidence of this being followed up.
• There was mixed feedback received from people and relatives about the service in general which demonstrated inconsistencies with the quality of care people were receiving. A person told us "I can't imagine living anywhere else where my needs would be as well met." However, a relative told us, "They've had some changes, the Mills family they want to try to run a good business but don't know how."
• The service has also been rated requires improvement since 2015 which demonstrates a continual lack of oversight and inability to make sustained improvements.

Systems in place were not robust enough and operated effectively to assess and monitor the quality and safety of the services provided to people and to consistently sustain improvement. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager has been in post since September 2019 and has applied to the CQC to become the registered manager of the service. The manager had started to work with the local authority to make improvements. Feedback from the local authority told us since the manager has been in place, positive changes and a lot of progress has been made including better communication amongst staff about their roles and responsibilities and improvements with monitoring the quality of the service
• Since the last inspection, the service had addressed some of the issues identified such as risk assessments and guidance in relation to falls and people who liked to use the stairs, a dependency tool to assess staffing levels was in place, care review meetings were in place to ensure people were involved with decision about their care, kitchen staff were aware of people's dietary needs, care records were updated to include people's sexuality, cultural and religious needs, people and relatives were involved with resident and relatives meetings and handovers were in place so staff were aware of any changes in people's needs.
• A condition was imposed on the service which required the provider to send monthly updates in relation to accidents and incidents. The manager has complied with this condition.
• Daily briefings with staff were also held with staff from nursing, maintenance, and kitchen staff to discuss areas such as staffing levels, people's needs, falls and accidents and incidents. The manager told us this helped improve communication amongst staff. Records showed any actions identified were followed up by staff.

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

At the focused inspection on 16 May 2019 and 17 May 2019, we found the provider did not always act in an open and transparent way. This was a breach of Regulation 20 (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 20.

• The manager understood their responsibility under the duty of candour and were open, honest and took responsibility when things went wrong. A duty of candour policy was in place and we noted communications to people and their relatives showed the manager and provider provided apologies and reassurances that action was being taken to minimise the risk of any reoccurrence of such events and any issues were resolved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• The manager obtained feedback from people and relatives through resident and relative meetings. Minutes of the meetings confirmed this and showed areas such food, activities, care plan reviews and the home environment were discussed, and any actions needed were followed up. People and relatives spoke positively about the meetings. A person told us "I go to the meetings, it's good to be informed." A relative told us "I went to the last meeting; it was very informative."
• Staff meetings were held to discuss the management of the service. Minutes of these meetings showed aspects of people's care were discussed and staff had the opportunity to share good practice and any concerns they had.

Working in partnership with others

• The service worked in partnership with key organisations including the local authorities that commissioned the service and other health and social care professionals to provide effective joined up care.

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<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>There were instances where people were not treated with respect<br><br>Regulation 10 (1) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were at risk of receiving unsafe care and support.<br><br>Regulation 12 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.<br><br>Regulation 17 (1) (2) (a) (c) |