

Community Integrated Care Martindale Road

Inspection report

329 Martindale Road
Hounslow
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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?

Requires Improvement ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Martindale Road is a residential care home providing personal care to seven people at the time of the inspection. The service can support up to seven people.

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

The service was not able to demonstrate how they were meeting some of underpinning principles of right support, right care, right culture.

Right support

People did not always benefit from an interactive and stimulating environment, or frequent support to take part in activities, so they did not have fulfilling and meaningful everyday lives.

Staff did not always communicate with people in ways that met their needs.

Staff enabled people to access specialist health and social care support in the community.

The service gave people care and support in a clean and well-equipped environment that met their physical needs. People and their relatives were able to personalise their rooms.

Staff supported people with their medicines in a way that promoted their safety and independence and achieved the best possible health outcome.

Staff supported people to maintain their health and access healthcare services.

Right care

People did not always receive kind and compassionate care that respected their dignity or promoted good end of life care.

People's support plans did not always reflect their range of needs to promote their wellbeing and enjoyment of life.

The service had enough staff to keep people safe. Staff had training on how to recognise and report abuse and they knew how to apply it. The service worked with other agencies to do so.

Staff received training and an induction to help them support people.

Right culture

The provider's monitoring processes were not always effective in helping to ensure people consistently received good quality care and support.

People and those important to them, including advocates, were involved in their care.

Staff turnover was low, which supported people to receive consistent care from staff who could get to know

them well.

The provider had a clear vision for the service based on a culture of improvement to enhance people's quality of life.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update

This service was registered with us on 21 June 2021 and this is the first inspection. The last rating for the service under the previous provider was requires improvement, published on 7 October 2020.

Why we inspected

We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. 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.

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 the service and will take further action if needed.

We have found breaches in relation to safe care and treatment, treating people with dignity and respect, person centred care, and good governance at this inspection. You can see the CQC's regulatory response to these concerns at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Martindale Road

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection was carried out by two inspectors and an Expert by Experience. 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

Martindale Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post. The service manager was also in the process of applying to become the registered manager.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We contacted the local Healthwatch branch to ask if they had received any information about the service; they had not. Healthwatch is an independent consumer champion that gathers and

represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection

Inspection activity started on 24 June 2022 and ended on 14 July 2022. We visited the home on 27 and 28 June 2022.

We spoke with five members of staff including the service manager and area manager, We also spoke with a visiting adult social care professional We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records relating to the management of the service, including procedures, staff supervision, audits and medicines support records for three people.

After our visit we spoke with five relatives and friends of people who use the service and two healthcare professionals who have worked with the service. We continued to seek clarification from the provider to validate evidence found. We looked at three people's support plans, training and quality assurance records, and recruitment data for three staff.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. We have rated this key question 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; Preventing and controlling infection including the cleanliness of premises

- Risks to people's safety were not always assessed, monitored and managed and they were not supported to stay safe.
- On 27 June 2022 we saw a number of hazards to the health, safety and well-being of people using the service. We found cleaning products stored in cupboards in the kitchen and main corridor that were unlocked. There were also exposed water pipes that were hot to touch in a cupboard that was also not locked. There was a set of unlocked drawers in the dining area that contained some tools.
- Staff completed daily temperature checks of the fridge and freezer to make sure food was stored safely. The freezer checks recorded for the three weeks prior to our visit were consistently not within the provider's required limits and noted no action taken in response to this. This meant the provider could not be assured that frozen food was always stored safely.
- The service had infection, prevention and control measures in place to keep people safe. However, we observed staff not always using personal protective equipment (PPE) appropriately. For example, we saw some staff wearing their face masks below their noses during their shifts. This was not in line with the provider's PPE guidance.

We found no evidence that people had been harmed however, these issues indicated the provider had not identified and managed the above risks to people's safety and wellbeing so they were supported to stay safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these issues with the managers and they took prompt action to address them. For example, they secured cupboards, ordered a new freezer and thermometer and implemented an audit of the temperature checks.
- The manager supervised a range of other checks to maintain a safe living environment. These included water temperature monitoring and electrical and gas safety tests.
- People's support plans set out risks associated with their daily living, including eating and drinking, taking medicines, health conditions and provided some basic actions for staff to reduce those risks.
- There were appropriate fire safety procedures, such as fire equipment checks, plans to help people evacuate if needed and fire awareness training for staff. The provider had plans in place to support the service in the event of an emergency, including finding alternative accommodation for people if required.

- The service had arrangements for keep premises clean and hygienic. We noted a bathroom extractor fan needed some cleaning and managers addressed this promptly. Professionals told us they had found the home clean.
- Staff were provided with sufficient supplies of PPE, such as masks, gloves and aprons and had received training on how to use this effectively.
- The provider tested for infection in people using the service and staff.
- The service's infection prevention and control policy was up to date.
- The service made sure infection outbreaks could be effectively managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- The service supported visits for people living in the home in line with current guidance.

Staffing and recruitment

- The service had enough staff to meet people's personal care and health needs and keep them safe. However, some staff told us there were not enough staff to be able to support people regularly with individual activities, such as going out and about. We discussed this with the managers who stated they were reviewing the staffing situation to enable the service to "support people to live the best lives possible."
- Staffing rotas indicated the same staff usually worked at the service which meant people could experience consistency in who provided their care and support.
- The provider had appropriate recruitment processes to help make sure they only employed suitable staff. Disclosure and Barring 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.

Using medicines safely

- People were supported by staff who followed systems and processes to administer, record and store medicines safely, including controlled drugs.
- People's support plans, personalised 'profiles' of their prescribed medicines and protocols for supporting people to take 'when required' medicines, such as for pain relief or in an emergency, provided information about their safe use. However, we saw one person's 'profile' and another person's protocol were not up to date. We discussed this with the manager who promptly corrected this.
- Staff used medicines administrations records (MARs) to record when they supported people to take their prescribed medicines. The MARs we saw were up to date, provided information to staff for safe administration and staff had completed them appropriately.
- People could take their medicines in private when appropriate and safe.
- Staff had completed training on how to administer medicines to people safely. The manager assessed their competency to do this.

Systems and processes to safeguard people from the risk from abuse

- People were kept safe from avoidable harm because staff knew them and understood how to protect them from abuse. The service worked with other agencies to do so.
- Staff had training on how to recognise and report abuse and they knew how to apply it. The manager promoted staff awareness during regular team meetings.

Learning lessons when things go wrong

- The provider had for systems in place for recording and reviewing incidents and accidents when these occurred, including taking further actions to reduce the likelihood of re-occurrence.
- The provider's systems identified learning and improvement actions from events from across its services.

This helped to ensure people received safe care because the provider learned from safety alerts and incidents.

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support, training, skills and experience

- Staff we spoke with appeared knowledgeable about people's personal care and health needs. However, the service supported two people at the end of their lives and staff had not received training on providing end of life care. We discussed this with the managers who stated they had identified this need and the provider was looking to source this training for the staff.
- Staff had completed other training to promote their competence in supporting people. This included emergency first aid, health and safety, mental capacity, safeguarding, and moving and positioning.
- Staff received support in the form of an induction to their role continual supervision, appraisal and recognition of good practice.

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

- People's support plans set out their food and drink preferences and there was a four-weekly rotating menu plan to guide staff preparing meals. However, when we observed a person refuse a meal staff explained this was because they thought the food was too spicy for the person and they then offered them cheese and some rice pudding as alternatives. It was not clear why the person was offered this meal if they were known to not like something so spicy. This meant on that occasion we were not assured that some people were always supported to eat food that readily met their personal preferences. We raised this with the managers so they could take action to address this.
- There was guidance in place to support people to eat safely when they were at risk of choking or needed their food to be a certain consistency. Staff we spoke with demonstrated they understood how to support people with this and a healthcare professional said staff did so appropriately.
- Records of daily care with saw showed people were supported to drink enough and eat a varied diet.

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

- The home was generally clean, light and suitably ventilated. The layout of the home supported people's needs, including access to the garden at the rear of the home. The service worked with a maintenance team to address any repair issues.
- There was a colourful, pictorial mural in the dining area. However, the large noticeboard there appeared to have information mostly for staff's benefit only.
- People and their relatives were able to personalise their rooms. There were some furnishings, such as textured wall hangings, to provide sensory stimulating opportunities for people.

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

- The previous provider had assessed people's care needs before they moved to the service. This had informed had people's support plans with information about their support needs, health and preferences. Support plans reflected issues such as people's age, ethnicity and gender.
- People's support plans that were personalised and reflected their personal care and physical health needs. People's relatives or friends were involved in reviewing people's plans.
- The service had worked with the local authority's positive behaviour support team to develop a plan to support a person when they expressed distress or agitation. A professional commented that staff's support had helped the person to experience times when they expressed agitation less frequently.

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

- The service supported people to meet their day-to-day health needs.
- Staff supported people to attend health checks and appointments. They referred people to health care professionals to support their wellbeing and help them to live healthy lives.
- Professionals told us staff and the manager worked well with them to support people's health needs. Staff supported a person regularly with an exercise activity and this had helped to improve their mobility.
- People had hospital passports which were used to help health professionals to support people in the ways they needed.
- People's support plans described the support they needed to manage their oral care. Care records indicated people were supported to see a dentist.

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.

- People were supported in line with the MCA.
- The provider had worked with the local authority when they found a person lacked the mental capacity to agree to their care arrangements and these may have amounted to a deprivation of their liberty. Comments from professional also indicated the service was supporting people in line with the principles of the MCA.
- The manager worked with an Independent Mental Capacity Advocate to help people if they lacked capacity and they had nobody else to represent their interests.

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant people were not always 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

- People were not always treated with dignity and respect.
- We observed instances of staff providing care and support without speaking with people. We saw staff moving people in their wheelchairs without informing them they were going to do this or why, or when a person was in the process of moving their chair independently. Similarly, we saw staff putting an apron on a person and taking it off without telling them they were doing this.
- We observed staff support people to eat their lunch without explaining to them what the food was. Staff used some paper towel more suited to wiping surfaces to wipe a people's mouths when they had been eating. Staff used spray to clean the dining table while a person was still eating. These issues demonstrated that staff did not always show warmth and respect when interacting with people.

People were not always treated with dignity or respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative also recounted an instance since our last inspection when staff had not treated a person with dignity and respect. They had raised their concern with the manager and the staff involved were no longer working at the service.
- We also saw staff provide respectful and attentive care at times. For example, speaking with a person calmly, explaining what a prepared drink was and helping them to reach this and take this independently.
- Staff described how they supported some people to achieve greater independence, such as encouraging a person to do things for themselves when washing areas or helping a person do some household chores like their laundry or sweeping.
- Relatives and professionals told us they had seen staff interacting with people, treated them "with respect and are friendly."

Supporting people to express their views and be involved in making decisions about their care

- Most people's relatives and friends felt involved in people's care. One relative said they would like more contact and updates about their family members' well-being.
- People's plans described how staff can support them to make some choices about their day to day care. For example, showing a person clothing options when getting dressed.
- The service worked with people's independent advocates. This also helped to give people using the

service a voice.

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant people's needs were not always met.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant; Planning personalised care

- People were not always supported to participate in or try meaningful activities on a regular basis.
- One person's support plan stated that they liked "intensive interaction with staff" and "enjoyed having interactions with staff." However, records of daily care noted that staff only supported the person with one activity, a manicure session. in the three weeks prior to our visit.
- Another person's plan stated, "Throughout the day I will remain occupied with doing some various of activities with the staff." However, daily records from the same time period showed they were only supported with three activities, which was listening to stories with staff twice on the same day and accessing the garden on another day.
- A relative told us, "There seem to be no activities" and "[The person] hardly ever goes out... [they] should go out more." A professional told us a person they worked with "could do with a few more activities."
- During our visit we observed the only activities available to people at home appeared to be music or television playing either in their rooms or in the lounge, or accessing the garden. We saw some people walking about the home or sitting in the lounge without staff. We also observed staff sitting in the lounge with people but not interacting with them.
- Some people's support plans set out aspirational quality of life outcomes their support aimed to help them achieve, but some people's plans did not. This meant it was not clear if staff used person-centred planning tools and approaches to plan with people what their how goals and aspirations might be and how to reach them.
- These issues showed the service did not always provide people with personalised, proactive and co-ordinated support in a planned manner.

The provider did not ensure people always received care and treatment which was appropriate, met their needs or reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff supported some people to attend a weekly music therapy session outside the home and we saw this take place during our visit. We also saw pictorial evidence that some people had been supported to go out for a walk, visit the local pub for a meal, visit an 'urban farm' and celebrate a Christmas and birthday party during the six months prior to our inspection.
- The manager reported that on some days staff supported some people to participate in different live online activities for people with a learning disability hosted by the provider.

- People's support plans provided some personalised information about them, such as some life history and their support needs. Staff we spoke with felt they knew people and their needs well and could access more information if they needed to.
- People's plans contained a clear one-page profile with important personalised information about the person, such as what was important to them, how best to support them and what others liked and admired about them.
- People had the opportunity to visit their relatives or friends and they could visit the home when they wanted to. The service facilitated people's contact with relatives.

Meeting people's communication needs

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

- The service did not always fully implement the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.
- We observed staff tell a person to "stop shaking" when they appeared to be engaging in 'stimming' or self-stimulating sensory behaviour.
- Staff we spoke with demonstrated some understanding of how people communicated if they were experiencing distress or would like something to drink, but could not always describe how they proactively communicated with people who did not use words to communicate. This indicated staff needed further support to understand how to facilitate good communication with people.
- People did not always have individual communication plans that detailed effective and preferred methods of communication, including the approaches staff should use with them. A person's support plan stated their "Communication needs are extremely limited" and their level of communication need was "Independent". However, the plan noted they did not use words to communicate and while it briefly described how they may communicate some choices physically, there was no information set out for how staff should approach the person and promote effective communication with them. There was no defined goal or outcome that such communication support should help the person to achieve.
- We noted appropriate communication support was detailed in two other people's support plans.

This meant the provider did not ensure that people always received communication support which was appropriate, met their needs or reflected their preferences. This was another breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- There were not always sufficient arrangements in place to support people to experience good end of life care.
- The service was supporting two people at the end of their life when we inspected. While another visiting care provider was also commissioned to provide personal care to these people, the home's staff we spoke with did not seem fully aware of peoples' end of life care needs or appreciate how to promote good end of life care. When we asked about end of life care training a member of staff told us, "We don't need to, as we don't do the care for them."
- We saw one person's support plan did not set out sufficient information about how to support the person compassionately with their end of life care. For example, there was no person-centred assessment of what may constitute a comfortable, dignified death for them based on their known wishes and preferences as the person could not communicate this themselves. This was not in line with national practice guidance for end

of life care.

The above also indicated the provider did not ensure that people always received care and treatment in a planned manner to meet their needs or reflect their preferences. This was another breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Healthcare professionals told us the service worked in partnership with them to provide end of life care to people. One professional spoke positively about how the manager had arranged a constructive meeting with a person's circle of support to discuss their end of life care.

Improving care quality in response to complaints or concerns

- The provider had systems in place for receiving and responding to complaints. The area manager reported that no complaints had been received.
- We saw the provider had systems in place to monitor complaints so these were resolved and to identify any learning for service improvements.

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement. This meant that while the service management and leadership were consistent, some systems did not always ensure people received high-quality, person-centred care.

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

- The provider's governance processes were not always effective in helping to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. This meant the service did not provide good quality support consistently.
- The provider's checks and audits to monitor the quality of the service and make improvements had not enabled the provider to identify and take timely action to address the issues we had found. For example, a quality audit completed in November 2021 identified there was minimal evidence people enjoyed activities that were meaningful to them. This was still an issue when we visited.
- The quality assurance systems had not always ensured that the service addressed risks to people's safety and well-being, that people were treated with dignity and respect, or that promoted their communication and end of life care support needs were met.
- A relative told us, "If I complain about anything it happens for a while and then it's back to normal." This indicated they were not confident that improvements were sustained.

These issues indicated systems were not consistently robust enough to demonstrate safety and quality was effectively managed. This placed people at risk of harm. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The managers were responsive to the matters we found. They planned to convene a training session on understanding care from a person's perspective and a 'service culture' workshop to reiterate their quality expectations of all staff.
- The provider's monitoring systems had already noted some of these issues and they had developed a service improvement plan to address these. The plan indicated some improvement actions had already been completed since the provider began responsible for the service, such as ensuring staff completed mandatory training and mobility equipment properly serviced.
- Relatives told us, "The staff are generally polite and helpful" and that their family member was "Always smiling when I go." A professional told us, "It is always very calm, not in a flap when I visit."
- Staff said they were happy working at the home and felt supported by the home's manager who had recently been nominated for an award from the provider in recognition of their work. Some staff, though, told us they did not always feel as valued by senior managers. Staff felt they worked together well as a team to support people.

- Professionals told us the manager was "organised [and] responsive" and informed about people's care and support needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider sought feedback from people and those important to them and used the feedback to develop the service. For example, through periodic surveys.
- Some relatives felt involved in the service while some said they "would like more direct communication and updates."
- The managers explained the provider was planning to relatives to regular webinars for relatives from across a number of services to enable them to be involved with the provider and the service provision.
- The manager held team meetings with staff to discuss and involve them in the service.

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; Continuous learning and improving care

- The managers articulated the provider's clear vision for the direction of the service which demonstrated ambition and a desire to improve the service for people to achieve the best outcomes possible.
- Strategic initiatives, such as the ongoing service improvement plan, demonstrated the provider was invested in the service and was working to deliver improvements.
- The provider had processes in place for responding and apologising to people when things went wrong.

Working in partnership with others

- The service worked in partnership with other organisations to provide coordinated care and support, such as healthcare and advocacy providers. A professional told us the service called them when needed and "We have good communications and work well with them."

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that service users' care and treatment was appropriate, met their needs or reflected their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users were treated with dignity and respect.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was always provided in a safe way for service users.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider was not operating effective systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity.</p>

The enforcement action we took:

Warning Notice