M L George

Clovelly House

Inspection report

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09 December 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clovelly House is a residential care home providing personal care to 17 people aged 65 and over at the time of the inspection. The care home accommodates up to 21 people in one adapted building.

People's experience of using this service and what we found
People's health, welfare and safety were placed at risk because the provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. There was a lack of management oversight of the service and the management team failed to understand the importance of this aspect of their role.

Comprehensive risk assessments were not in place to ensure staff knew how to keep people as safe as possible. Staff did not have the competence or skills to respond appropriately in emergency situations, which put people at risk. There was not an effective system in place to learn lessons from incidents or accidents. Staff numbers and deployment meant that people were not always fully supported in the way they wanted to be and there was a risk that both people and staff were not safe. Medicines were not managed safely.

The provider did not have a satisfactory system in place to ensure that people were protected from abuse and harm. Staff did not have the training or support to carry out their role in line with current good practice guidance and did not always support people to eat and drink enough.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and procedures in the service did not support this practice.

Staff did not always show respect for people or treat them as adults. People were not always given opportunities to make decisions about their care and did not have many choices about the way they led their lives. Staff did not always encourage and support people to maintain their independence.

Care plans had not all been updated or reviewed so staff did not have sufficient guidance to provide each person with the care they wanted. Staff were not always following care plans and records of care were incomplete. The provider had failed to ensure that people would receive the best possible care, in line with their preferences, at the end of their lives as no end of life care planning had been done.

At the start of the inspection there was a serious risk in the event of fire as fire safety arrangements were not robust enough. The provider addressed some of the issues so fire safety had improved by the third day of the inspection.

People told us they felt safe and were happy living at Clovelly House. Relatives were satisfied with the care

people received. Activities were organised and people told us they had enough to do. New staff were recruited in line with the regulations and staff were aware of their responsibilities to protect people from the spread of infection.

People spoke highly of the staff and liked the food. People and their relatives knew how to complain but had never needed to. Staff involved other healthcare professionals to support people to maintain their health.

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

Rating at last inspection
The last rating for this service was good (report published 23 May 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding including the number of falls and serious injuries; care planning; and a number of other concerns about the safety and effectiveness of the care being provided to people living at the home. A decision was made for us to inspect and examine those risks.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clovelly House on our website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to safe care and treatment; good governance; person-centred care; consent to care; staffing; and safeguarding people from abuse and avoidable harm.

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

Following the first two days of the inspection we had serious concerns around the safety of people using the service. We wrote to the provider asking them to tell us about the actions they had taken to reduce the risks. We returned to the service on 9 December 2020 to check that the provider had taken the actions and we found they had not done everything they told us they had done.

Therefore, we stopped the provider from admitting any more people to the service without our permission. We required the provider to ensure the service is audited by a competent person to provide an accurate oversight of the service and to send us a weekly summary of the audits. This summary must include actions taken to ensure people receive safe and effective care.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Clovelly House

Detailed findings

Background to this inspection

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

Inspection team
On 27 November 2019 and 3 December 2019 two inspectors carried out the inspection visits. On 9 December 2019 one inspector was accompanied by an inspection manager.

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

The service did not have to have a manager registered with the Care Quality Commission, as long as the provider remained in day to day control. This means that the provider is 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 on 27 November 2019. We told the provider we would be returning for the second day of the inspection on 3 December 2019. The third day of the inspection, on 9 December 2019, was unannounced.

What we did before the inspection
We looked at information we had received about the service since the last inspection. We asked for feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who lived at Clovelly House and three people's relatives about their experience of the care provided. We spoke with nine members of staff including the provider, the manager, the deputy manager, care workers, two members of the housekeeping team and the cook.

We looked at a number of records. This included six people's care records, four people's medication records and records relating to the management of the service such as meeting minutes, accident/incident records and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider had failed to ensure that risks to people were assessed, monitored and managed, which meant people were at serious risk of avoidable harm. Comprehensive risk assessments had not been completed, for example for people's risk of experiencing a fall or their risk of developing a pressure ulcer. This meant that staff did not have the information they needed about how to keep people safe from harm.
- We found significant risks in relation to fire safety. Personal emergency evacuation plans (PEEPs) were not in place for everyone at the start of our inspection. Some of those in place were not accurate so would not have kept people safe in the event of an emergency. The home's fire risk assessment had not been reviewed since May 2017. By the third day of the inspection the provider had updated the PEEPs and reviewed the fire risk assessment. We reported our concerns to the fire service.
- Staff had not always acted appropriately to ensure people received medical assistance as quickly as possible in an emergency. This had meant there had been a risk that people's medical condition had deteriorated before they received medical attention.

Learning lessons when things go wrong

- The provider had no system in place to learn lessons when things went wrong. Staff completed records of incidents and accidents but no analysis of these took place and no actions were taken to prevent recurrence.
- One person had a fall and the managers told us they had not fallen previously. We found records to show that they had fallen within the previous four months. However, their risk assessment had not been reviewed to see if any further action needed to be taken to prevent a recurrence. In another example, the provider had signed off an incident record but had not recognised that staff had not acted appropriately. A similar incident then occurred. This placed people's health, safety and welfare at risk.

Using medicines safely

- The provider had not ensured that medicines were managed safely. We found discrepancies in the number of tablets remaining in the boxes for three of the seven different medicines we checked. This meant there was a risk that people had not always been given their medicines safely or as they had been prescribed.
- On the first day of our inspection, staff were not able to find the correct records or locate stock of a medicine. Records of medicines received, given, carried forward or disposed of were not accurate enough for us to follow an audit trail to explain the discrepancies between the records of medication administration and the number of tablets remaining in stock.

Staffing

● There were not enough staff deployed, with sufficient skills, experience and knowledge, to meet people's needs and keep them safe. People and staff had mixed views about whether there were enough staff on duty. The provider used a dependency assessment tool to work out how many staff were needed on duty. At the time of the inspection there were three care staff in the mornings, two care staff from 6pm to 9pm and one care staff at night.
● Staff said in the mornings the alarms were continually ringing because two staff were needed to assist people to get up and the third member of staff was giving people their medicines. People told us they did not choose what time they got up. If a person required two staff to assist them to move during the night, the staff member on duty had to ring the on-call member of staff. One person's care plan indicated they needed three staff to assist them to transfer.

Comprehensive risk assessments were not in place to ensure staff knew how to keep people as safe as possible. Staff did not have the competence or skills to respond appropriately in emergency situations, which put people at risk. There was a serious risk in the event of a fire as fire safety arrangements were not robust enough. There was not an effective system in place to learn lessons from incidents or accidents. Staff numbers and deployment meant that people were not always fully supported in the way they wanted to be and there was a risk that both people and staff were not safe. Medicines were not managed safely. All the above placed people's health, welfare and safety at risk. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the first two days of this inspection the provider produced some guidance for staff on how to respond to emergency situations and fire safety had been improved; we reported our findings in relation to fire safety to the fire officer, who the provider also contacted; and the provider arranged for a pharmacist to carry out an audit of medicines and do some additional training for senior staff.
● The provider and staff team made sure people received consistency of care by not using agency staff. Following the inspection, the provider confirmed their own staff always managed to cover if their colleagues were off sick or on holiday.

Systems and processes to safeguard people from the risk of abuse
● People were placed at risk of harm because the provider did not have a robust enough system in place to ensure that people were protected from the risk of abuse. Staff had not always reported possible abuse or harm. For example, we found a number of instances where staff had recorded 'unknown bruise' on a body map but had failed to complete an incident form or report to management. This had meant that the possible causes had not been investigated or any appropriate action taken.
● Staff, including the management team, had not always made referrals to the local authority's safeguarding team when an allegation of abuse had occurred. This had been an issue raised with us by the local authority. We found another incident that the management team had not recognised as abuse and had not reported. One of the management team demonstrated they had very limited understanding of safeguarding: they told us as the incident was a "one-off" it did not need to be reported. They had no evidence that the incident was not a regular occurrence and had put nothing in place to ensure it did not happen again.

People were at risk of abuse as staff were not following the local authority's safeguarding protocol. They were not always reporting incidents of possible harm or abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people told us they felt safe. One person said, "I've never had anything to make me feel unsafe." The

other person said they could lock their bedroom door if they felt unsafe. People's relatives were satisfied that their family members were safe.

Recruitment

● The provider had a recruitment procedure in place, which staff told us had been followed when they had been appointed. They said pre-employment checks including references and a criminal records check, through the Disclosure and Barring Service (DBS), had been in place before they started working with people.

Preventing and controlling infection

● The home was clean and smelled fresh throughout with no unpleasant odours.

● Staff had undertaken training and were fully aware of their responsibilities to protect people from the spread of infection. They wore gloves and aprons when providing personal care to people.

Inadequate

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 deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

- People's legal rights were not protected because staff had not ensured that each person's capacity to make particular decisions had been assessed. Best interest decisions had not been made in line with the MCA and had not been recorded.
- We found that staff, including the management team, did not have a good enough understanding of the principles of the MCA to be able to apply these principles to their work. For example, for one person a manager had filled out a brief mental capacity assessment form. They had shown that the person had capacity to make decisions but had then written 'staff to act in [name's] best interests', which is not in line with the principles of the MCA.
- The provider had failed to identify the use of restraint which was unlawful and not in line with best practice. Equipment such as alarms and alarm mats had been put in place to alert staff if people moved around, without people giving their consent. When we asked one person whether they had agreed to have an alarm in their room they said, "[Staff] just do what they think they must."
- One person had a DNAR (Do Not Attempt Resuscitation) form in place. The form did not show that the person had been consulted about this. The management team had not considered the person's mental capacity and there was no documentation in the home to show that the person's relative had the legal right to make decisions on the person's behalf.

The provider had failed to ensure that people's capacity to make particular decisions had been assessed

and recorded. They had failed to identify and manage the use of restraint. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not always have the skills and knowledge to carry out their role. Staff had undertaken a range of training and further training courses had been arranged. However, staff had not always learnt from the training. For example, they showed they did not understand their responsibilities regarding safeguarding people from abuse and avoidable harm. They also showed very little understanding of the principles of the Mental Capacity Act 2005.
● Staff did not feel fully supported by the managers or the provider to carry out their role. They had not all received supervision on a regular basis and they did not always feel listened to.

The provider had failed to deploy a sufficient number of staff who had received adequate and suitable training and support to enable them to carry out the duties they were required to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first two days of our inspection, the provider had arranged training for the management team in safeguarding and mental capacity.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff did not always support people well enough to make sure they ate and drank enough. One person had lost a significant amount of weight. Although a referral to the dietician had been made several months previously it had not been followed up in a timely manner when there was no response. We saw this person, who had chosen to eat their meals in their room, struggling to get the food from the plate to their mouth. Staff had delivered the person's pudding before they had finished their first course and both were stone cold. No staff had returned to offer assistance.
● People told us they liked the food. However, people were not offered many choices. One person told us they had said what they wanted for breakfast when they first arrived at the home, several years previously. They were still having the same breakfast brought to them each morning. There was one meal on the menu each day for lunch: the cook knew who did not like that meal and that person was offered an alternative. At lunchtime, staff put a drink (orange squash or water) on the table for each person before people arrived in the dining room, so people could not choose to have a different drink.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The district nursing team supported the staff for all medical interventions, such as insulin injections and would dressings. A GP visited the home regularly.
●One person told us they could see their GP whenever they wanted to. However, staff had not sought support as urgently as they should have done for one person who was losing weight.
●There was not always a clear record of outcomes of medical appointments so that all staff were aware.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The management team told us they assessed each person's needs before the person was offered a place at the home. They also ensured any equipment required was in place before the person was admitted.
● The provider had not ensured that staff were kept up to date with current good practice guidance so that the care they delivered to people achieved effective outcomes.

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

● Clovelly House was an adapted residential house, which had been open for many years. The provider had made further adaptations as required. For example, a stairgate had been installed to prevent people from going upstairs if they were not safe to do so. This had been designed to look exactly like the banister so that people did not recognise it as a gate, so did not try to open it.
● The provider had some dementia-friendly signage in place, such as indicating which were toilet doors.

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 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

- Staff treated people with kindness and compassion and people and their relatives spoke highly about the staff. One person said, "[Staff] make sure we're comfortable. We're very well looked after." Another person told us, "Staff are all very friendly and helpful." Relatives also praised the staff. One relative said, "The staff are lovely, friendly, welcoming and offer cups of tea."
- Staff did not always show respect for people. For example, the language used in people's daily records was not always respectful. Some of the words used were the staff member's opinion and did not describe what had happened.
- Staff sometimes treated people as though they were very young children, not respecting their rights as adults to make their own decisions. This meant people were not always treated in line with the Equality Act 2010.

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

- People were not always given the opportunity to make decisions about their care. Some staff had worked at the home for a very long time and some of the care provided, although done with the best intentions, was described by a healthcare professional as "old-school". A member of staff said, "Some staff are so set in their ways they can't see we're here for the residents."
- People were not always involved in developing and reviewing their care plans.
- People were not given a wide enough range of choices in all aspects of their daily care.

Respecting and promoting people's privacy, dignity and independence

- Staff did not always respect people's dignity. For example, while in the lounge we overheard a staff member say, "[Name of person] has just been to the little girl's room" in front of other people and visitors.
- The culture in the home did not fully promote people's independence. On occasion, staff provided support to people who could have done more for themselves. For example, staff took several people in wheelchairs from where they had spent the morning to the dining room, instead of encouraging them to walk. A member of staff said, "There's no time to encourage people to do things for themselves."

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 good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Staff did not always have the information they required to meet people's needs. Each person who lived at Clovelly House had a care plan in place. The manager was reviewing and updating care plans to ensure they included current information. They told us that this was "work in progress" and not all care plans had been updated. We found that even those care plans that the manager told us had been "updated" did not contain up to date information. This meant that guidance in place for staff on how to meet the person's needs was incorrect and there was a risk that people's needs were not being fully met.

● The provider told us that people who stayed for a respite break had a shorter care plan. However, on investigation, the provider found that the care plan for the person who had been admitted three days before the inspection did not contain even the basic information that the staff needed to care for the person in the way they preferred.

● People did not always receive the support they required. The deputy manager told us that due to an injury one person spent all their time in their bed or chair. This put them at risk of developing pressure areas, so they needed regular repositioning. However, this information was not in their care plan. Furthermore, their daily records and charts showed that there were gaps of up to eleven hours when the person had not been repositioned. The home's records showed staff had noted red areas on the person's skin and a referral to a district nurse should be made. However, this had not been done. This placed the person's health and welfare at risk.

End of life care and support

● The provider had failed to ensure that people received the best possible care, delivered in line with their preferences, in the final stages of their life. The manager told us there were no end of life care plans in place and added, "These are conversations we need to be having." This meant that in the event of sudden terminal illness or death, people might not get the care they would have wanted.

● The manager told us at the time of the inspection no-one was on end-of-life care. The staff team worked closely with a district nursing team who had supported them on previous occasions when a person had reached the end of their life.

The provider had failed to ensure that people received person centred care. They had failed to ensure that people's care plans were fully person-centred, contained people's preferences and were kept up to date. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● The provider had made little attempt to ensure that information for people was accessible. Care plans and other documents such as the complaints procedure were not available in large print or any other format.

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

● People told us there was a range of activities that they could take part in if they wanted to. People had taken part in making a Clovelly House Christmas card as well as other things for Christmas. One person said they particularly enjoyed the arts and crafts sessions and a lot of people joined the weekly exercise class.

● All three relatives we spoke with were satisfied that their family members had enough to do within the home. One relative said, "[Family member] never seems bored, frustrated or restless."

● The manager told us they had taken craft items to one person's room, so they could join in even though they could not get to the lounge. One relative suggested that "more trips out" would add to people's enjoyment.

Improving care quality in response to complaints or concerns

● The provider had a complaints process in place: the manager said they had not received any complaints since they had taken up their post. People and their relatives knew how to complain if they needed to. One relative said, "If I had a complaint I'd email [the manager] and see what happened. If nothing, I'd talk to [the provider]."

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 good. At this inspection this key question has 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

●The service was not well managed and the provider lacked oversight of staff performance, quality standards and the care that was being delivered. The provider had failed to recognise their responsibility to ensure that the service delivered to people gave them high quality, safe care. They had failed to recognise the importance of regularly monitoring the quality of the service. The provider stated that audits were the responsibility of the manager and deputy manager and they did not see them.

● Furthermore, the provider had failed to identify and address areas of care which required improvement. We found significant shortfalls, which had not been identified by the audits that had been carried out. There were no systems in place to provide continuous learning and improvement in care practices.

● The failures we found included: the failure to recognise and respond to concerns appropriately and in line with safeguarding policies and procedures; the failure to assess, monitor and review people's safety and well-being; the failure to assess capacity where appropriate and work within the principles of the MCA; and the failure to identify the use of restraint within the service, which was unlawful and not in line with best practice. The local authority had already identified some of the areas for improvement and fed this back to the service. However, the necessary improvements had not been made.

● In addition, the failure to ensure there were sufficient staff deployed with appropriate skills and competence to provide care that was safe and met people's needs; the failure to ensure staff knew how to respond in an emergency; the failure to ensure and monitor that people received personalised care; the failure to maintain accurate, complete and contemporaneous records; and the failure to have a system in place to learn from incidents.

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

● This service did not require a registered manager as long as the provider was in day to day control. The provider had appointed a manager and also had a deputy manager in place.

● The management team (the provider, the manager and the deputy manager) did not fully understand quality performance, risks or regulatory requirements. This was demonstrated by the failings we found in the service.

● Monitoring of the records by the management team was inconsistent or not done at all. On the second day of our inspection we found this area of care had not improved. We told the provider that we were going to take enforcement action if they did not tell us, within 24 hours, how they were going to improve. They sent us an acceptable action plan. However, when we returned to check they had done what they said they would do (the third day of the inspection) we found they had failed to do so. We took urgent action to

protect people using the service.

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

● The provider did not have a robust system in place to seek the views of people involved with the service, including the staff, and to use those views to improve and develop the service.

● Staff meetings were held but staff said they did not find them helpful. One member of staff said, "Staff meetings aren't very useful – we just have to sit and listen and aren't able to give our opinion."

● People and relatives could not recall completing any formal surveys to enable them to give their views about the service being provided.

The provider had failed to monitor and improve the quality and safety of the services provided. The provider had failed to maintain accurate, complete and contemporaneous records. This was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of the inspection the manager had been in post for eight weeks. People, relatives and staff all made positive comments about the manager, finding them approachable and friendly. A member of staff said, "[Name of manager] is very positive and wants to do a lot for the home and the residents."

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

● People and their relatives were happy with the care they or their family members were receiving. One person told us, "It's enjoyable here. I'm really happy – I've been treated really well." A relative said, "[This home] is the best in March." They added the home feels very welcoming and homely. Another relative, who had not wanted their family member to go into a care home, said, "If she had to go into a home, I'm glad it's here. It's brilliant."

● Many of the staff had been at the home for a very long time (up to 30 years). Staff all told us how much they loved working there and loved their job. A member of staff said, "I absolutely love it here."

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

● People and their relatives had no concerns that the provider was not open and honest with them. A relative said, "They're very open."

Working in partnership with others

● The staff team worked in partnership with commissioners from the local authority and with health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was provided to people with their consent and in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to put systems in place to ensure that people were protected from abuse and avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy a sufficient number of staff who had received adequate and suitable training and support to enable them to carry out the duties they were required to perform.

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 that care and treatment was provided to people in a safe way.

The enforcement action we took:

We imposed conditions 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 The provider had failed to put systems in place to effectively assess, monitor and improve the quality and safety of the service provided to people.

The enforcement action we took:

We imposed conditions on the provider's registration.