Layden Court Care Home Ltd

Layden court Care home

Inspection report

All Hallows Drive
Maltby
Rotherham
South Yorkshire
S66 8NL

Tel: 01636673017

Date of inspection visit:
25 May 2022
14 June 2022

Date of publication:
11 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Layden Court is a care home providing personal care and nursing. It can accommodate up to 92 people. Some people using the service were living with dementia. There were 54 people using the service at the time of the inspection.

People's experience of using this service and what we found
People were not always safe, risks were not effectively managed to ensure people's needs were met and safety maintained. For example, risk of weight loss was not managed, people had lost considerable weight and there was a lack of systems in place to manage the risks. Infection prevention and control (IPC) practices were poor. We found many areas that were not clean and areas that were not well-maintained to enable effective cleaning. On our second site visit we found some improvements in cleanliness. However, we still found areas that were not clean, and staff did not always follow good IPC practices. For example, masks not worn properly and staff not changing PPE when required.

Staff received supervision; however, this was not always effective. Most staff we spoke with told us they did not feel supported. One staff member told us, "There is lack of communication from management, we [care staff] are not supported." We observed poor practices that had not been picked up as part of staff supervision or quality monitoring. For example, poor IPC practices and staff lacking an understanding of person-centred care.

There was a dependency tool used to determine staffing levels. However, it was not clear if there was adequate staff on duty to meet people's needs. We observed staff were not present in communal areas or available on units when people required assistance. Medication procedures were predominantly followed. However, we found some minor issues, regarding documentation and lack of oversight of records.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice. Staff received specific training. However, this was not effective as staff were not following best practice. The environment was not dementia friendly and staff did not understand how to meet the needs of people who were living with dementia. People's nutritional needs were not always managed effectively. People were not given choices at mealtimes and there was lack of support. It was not clear if advice from health care professionals was being followed to ensure people received adequate nutrition.

People told us staff were caring and kind. However, we observed staff did not always support people appropriately. Their approach was not always person-centred and at times was task orientated. Staff did not always respect people's privacy and dignity.

There was lack of social stimulation and activities provided. The registered manager had employed a new

activity coordinator and they were commencing activities. However, there was no stimulation or appropriate activities provided for people living with dementia. Complaints were recorded in line with the provider's policy. However, not all concerns had been documented and dealt with appropriately. This did not evidence actions had been taken to minimise issues reoccurring. End of life care plans were in place, but they were very brief and did not identify people's preferences, religious beliefs or choices.

Systems and processes used to ensure the service was running safely were not robust or effective. We identified many shortfalls during our site visit that had not been identified as part of the quality monitoring. For example, IPC practices, person centred care, effectiveness of training and staff deployment.

Feedback from relatives varied depending on which unit their family member lived on. Some relatives did not feel involved in the day to day running of the home. They felt communication was poor and they were not kept informed of issues or general welfare of their loved ones.

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

Rating at last inspection
This service was registered with us on 01/12/2021 and this is the first inspection.

The last rating for the service under the previous provider was requires improvement, published on 29 January 2020.

Why we inspected
The inspection was prompted due to concerns received from the local authority commissioners. These were regarding, poor care and support provided, lack of robust infection prevention and control and ineffective governance and management of the service. As a result, we undertook an inspection looking at all five key questions.

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.

We have found evidence that the provider needs to make improvement. 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 Layden Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person-centred care, consent to care and treatment, staffing, and leadership and oversight at this inspection.

Follow up

We will continue to monitor information we receive about the service until we 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Layden court Care home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 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
Layden Court is a 'care home'. 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.

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.

Notice of inspection
This inspection was unannounced. Inspection activity started on 25 May 2022 and ended on 14 June 2022. We visited the home on 25 May and 7 June 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. 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 this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and nine relatives about their experience of the care provided. We spoke with fifteen members of staff including the registered manager, deputy managers, nurses, senior care workers, care workers, ancillary staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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. This included eleven people's care records, medication records and weight records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service.

Inadequate

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 for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not effectively managed. For example, people had lost considerable weight. Although a referral to a dietician had been made, we found advice was not followed. For example, people were not always weighed weekly or monthly in line with advice. Food charts were not completed properly, were not monitored, evaluated or reviewed.
- Weights were not recorded in people's care plans. We found the information recorded on a sheet of paper listing people's names and weights. This had not been reviewed in people's care plans to ensure their needs were met.
- Accidents and incidents were reviewed and monitored by the registered manager. However, there was lack of evidence this drove improvements. For example, one person had a number of incidents, staff told us this happened when there were unfamiliar staff on the unit. On the day of our second site visit the staff allocated to the unit were either new or had not worked with the person for over six months. Therefore, the trigger for the person's anxiety was not managed.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Environmental safety checks were carried out. We saw the provider was taking action to address any issues identified. For example, fire safety improvements were ongoing.

Using medicines safely

- Systems were in place to ensure safe management of medicines. Predominantly these were followed. However, we identified documentation issues. The topical medication administration records (MAR's) were not completed. These were not monitored or reviewed so the issues had not been picked up.
- Medicines had not been received into the home and people some people had not received medicines for three days. Staff had been trying to resolve the issue. However, had not taken appropriate action to ensure medicines were obtained in a timely way.

The provider had failed to ensure the proper and safe management of medicines which is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The environment was not clean.
- We found areas of the home were not thoroughly cleaned. For example, mattresses, bath and shower chairs, toiled raisers, lounge chairs and pressure relieving cushions were all heavily stained with urine and

excrement.
● We also found furniture, equipment and the general environment was not well maintained. This made it difficult to clean effectively. For example, there were missing wall tiles in bathrooms, damaged floor coverings, areas of untreated wood that were porous and furniture falling apart. We were not assured by the infection control systems in place.
● Staff did not always follow guidance regarding personal protective equipment (PPE). Staff did not wear mask correctly, did not always wash hands and did not change PPE when required. We found bags of opened clinical waste on top of bins in sluice areas and hand sanitiser and soap dispensers empty.
● The IPC audit had not identified the issues we found. On the second day of our site visit we did see some improvements. However, we still found areas of the home which were not clean, and staff did not always follow best practice in infection prevention and control.

The provider had failed to ensure the proper and safe infection, prevention and control which is a breach of regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The registered manager used a dependency tool used to determine staffing levels. However, it was not clear if there were adequate staff on duty to meet people's needs. We observed staff were not present in communal areas and staff did not respond to people's calls for assistance in a timely way.
● Staff we spoke with told us there were not enough staff on duty. A number of staff said they had to manage on their own when the people they were supporting required two staff to meet their personal care needs. One staff member said, "I know I am not following the care plan, but I have to move [people] on my own as there are no other staff on the unit. I can't let them [people] stay wet and uncomfortable. I know it is wrong, but I have no choice."
● Staff received training. However, the training was not effective. We observed staff did not provide person-centred care. Staff did not understand how to meet the needs of people living with dementia and we observed inappropriate moving and handling of people.

The provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed, which is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a staff recruitment system in place. The files we saw showed pre-employment checks had been obtained prior to staff commencing employment.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes in place to safeguard people from abuse. However, we reported three safeguarding concerns to the local authority following our site visits.
● Staff were knowledgeable about safeguarding and what should be reported and told us if they had concerns that a person was being abused, they would report it to their line manager.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 provider was not always working within the principles of the MCA.
- There was best interest documentation in place where people lacked capacity to make decisions. However, we found no best interest decisions completed for people who were cared for in bed. Therefore, people's wishes were not considered, depriving people of their liberty keeping them isolated in their bedrooms with no clear reason why.
- DoLS were not always applied for in a timely way, the lack of DoLS submissions was identified by the local authority, the registered manager assured us these had now been submitted. We also found where people had authorised DoLS with attached conditions these were not always followed. For example, one person's condition to have access to a vicar had been in place since August 2021.This had not been facilitated. The registered manager took action following our visit to address this.

The provider had failed to ensure there were working within the principles of the MCA, which is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff received mandatory training. The training records we saw showed staff had received most training. However, from our observations and talking with staff we noted the training was not effective. For example, staff did not provide person centred care. We observed inappropriate moving and handling and staff did not understand the needs of people living with dementia. We also found infection control procedures were not always followed by staff in line with best practice guidance.
- Staff received supervision. However, this was not effective, it had not identified staff's lack of competence

in fulfilling their roles and responsibilities.
● Staff told us the registered manager was approachable and listened but did not follow things through or give you any feedback or outcomes. Therefore, they did not feel well supported. One staff member said, "Manager doesn't listen, I don't feel supported." Staff told us they did not receive a thorough induction had limited support and training before they started work on the units.

The provider had failed to ensure staff were suitably competent, skilled and experienced, which is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were not always assessed.
● Staff were not knowledgeable on how to meet people's needs. For example, staff did not know how to approach people who were living with dementia when they presented with behaviours that could challenge.

● People's care plans we looked at did not always include people's preferences and choices. Many new staff had been employed and there was also a high use of agency staff. This meant staff did not know people's preferences.
● The registered manager and provider had identified care plans required work and were in the process of reviewing and updating people's care plans. However, care plans that had not been reviewed, were not evaluated or updated when people's needs changed. This meant the care provided was not person-centred.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to maintain a balanced diet that met their needs.
● We identified some people had lost weight, although this had been picked up and referrals made to health care professionals, their advice was not always followed. For example, weekly weights were not recorded, and food and fluid charts were not completed properly, monitored or evaluated.
● There was no evidence recorded on food records that people's diets were fortified or enriched, which is where extra nutrients are added.
● Relatives told us the food was poor, repetitive and lack of choice. One relative told us, "On Friday it was either hot dog or burger there was no salad or pudding."
● The meal service varied depending on which unit people lived. The meal service for people living with dementia was not a positive experience. There were no picture menus or plated food shown to assist people's choice, many people were not given the choice to go to the dining room, there were insufficient staff available to assist people in a timely way, food was left on the side in the kitchen going cold as there was no hot trolley available on one unit. The meal service was not person centred and did not met people's needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with health care services obtained advice. However, this was not always followed. There was no evidence in care plans or documentation that best practice guidance was adhered to ensuring effective timely care. For example, dieticians had been contacted, and had advised people should be weighed weekly and their food intake should be monitored. However, this was not followed.

Adapting service, design, decoration to meet people's needs
● The environment was not dementia friendly and design and decoration did not follow best practice guidance. For example, colours, signage and lack of social stimulation and activities for people living with dementia.

The provider failed to ensure people received person-centred care, which is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 for this newly registered service. This key question has been rated inadequate This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity. Respecting and promoting people's privacy, dignity and independence

- People told us the care staff were nice and were kind and caring. However, they were very busy. Relatives told us some care staff were very kind. One relative said, "Staff are lovely with [relative] I can't fault that aspect, but they are extremely busy, run around like headless chickens most of the time."
- We found people were not always well treated or supported. We spent time observing staff interacting with people. We saw when staff did engage, they were kind and caring. However, on most occasions we saw staff did not engage with people when providing care and support and were task orientated. For example, staff took meals into people's bedrooms and left the meal on the table with no support offered. One visitor told us, "I found [person] leaning over trying to get food off the floor which they had dropped, while trying to eat and staff [agency] were sat in the office on their phone."
- People living with dementia were not supported in a meaningful way to enable them to express their views. We saw staff did not interact or provide any meaningful stimulation. There was no visual stimulation and best practice was not adhered to, such as appropriate use of colours, pictures and tactile objects.
- People's preferences were not considered as part of their care and support. For example, one person's care plan stated they liked to be involved in activities, yet the staff had made the decision to keep them in bed, which socially isolated them.
- We observed staff did not always respect people or promote their privacy. For example, we saw a person in their room with their trousers and underwear pulled down and no staff ensured their dignity was maintained. Staff had not noticed when people's clothes were wet or stained. We found people with heavily stained, food encrusted clothes that had not been changed after their meal. People had dirty nails.
- People's independence was not always promoted. Staff did not support or encourage people to do things for themselves.

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

- During our observations we saw people were not involved in decisions about their care. Staff did not always explain the tasks they carried out.
- Care plan documentation did not reflect that people had been involved in creating and updating them. Although new care plan documentation was being introduced as care plans were reviewed and rewritten.

The provider failed to ensure peoples care and support was person-centred, which is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which met their needs

Inadequate

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 for this newly registered service. This key question has been rated inadequate This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences. Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person-centred care which met their needs and preferences.
- We found people kept in bedrooms or in bed, with no clear explanation of why this was necessary. People were not supported appropriately with their personal care or nutritional needs. Staff did not have the knowledge to meet people's needs who were living with dementia.
- Relatives told us they were providing care and support, as staff were unable to meet people's needs.
- People were not always supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.
- The registered manager had recently employed a new activity co-ordinator to improve people's access to social stimulation and prevent social isolation. The activity co-ordinator was motivated and wanted to provide positive stimulation. However, they were working over four units, including two units for people living with dementia. They felt they did not have sufficient time to spend with people on a one-to-one basis, although they felt some people would benefit from this. The activity co-ordinator was new to their role and said they would like some training to help them in meeting people's needs.
- People told us they were bored. One person said, "it can be boring. They have started an activity service now." They hoped things would improve. Relatives we spoke with told us there was a lack of activities and social stimulation. One relative said, "[Person] is fed up. What can they do?"

The provider had failed to ensure people received person-centred care, which is a breach of regulation 9 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.

- We found these standards were not always followed. Staff did not communicate effectively with people and there was lack of information in a format that people living with dementia could understand.
- During our observations we found staff did not use accessible information to enable people to communicate effectively. For example, at the mealtime there were no picture cards to assist people with making menu choices.
- Relatives told us communication was very poor. For example, one relative said, "We were not informed when visiting was resumed."

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure. We saw the registered manager kept a record of complaints. However, they had not documented all the concerns received.

● Relatives did not always feel concerns were appropriately dealt with. Relatives told us they had raised concerns with the registered manager, and they had felt listened to at the time these were raised. However, they have not been resolved. Therefore, it was not clear if appropriate action had been taken.

The complaints, concerns and communication was not effectively audited to ensure the providers policies were followed, which is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● People had end of life care plans, but they did not always identify people's preferences and choices.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service had a registered manager. They had been registered with the previous provider and transferred to the new provider in the same role.
- The staff received supervision. However, we observed they were not clear about their roles and responsibilities and did not understand the regulatory requirements. Staff told us they had not always felt supported and felt there had been lack of guidance.
- There had been a lack of provider oversight. However, the provider did acknowledged the service needed to improve and have implemented a special measures plan to drive improvements.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems in place to monitor the service were not effective.
- We identified a number of issues during our inspection that had not been identified as part of the provider's quality monitoring, For example, shortfalls in IPC practices, lack of person-centred care and poor deployment, direction and leadership of staff.
- Where issues had been identified, the registered manager and provider had not always effectively overseen or ensured actions were taken to maintain or improve the quality and safety of the support being delivered at the service. For example, the registered manager had identified some IPC issues, but prior to our visit these had not been resolved. Following our visit some actions were taken immediately to address shortfalls, which could have been resolved when they were initially identified.
- Internal systems for staff management, appraisals and supervision were not operating effectively to ensure staff understood and were able to fulfil their responsibilities. They did not support staff to be positively accountable for their performance. Staff told us their performance, induction and competencies were not managed well. They explained they did not feel confident and capable of supporting people, especially people living with dementia who could present with behaviours that may challenge and get distressed.
- Staff did not feel they were able to fulfil all their duties to a good or safe standard. Two members of staff told us, at times they had to move and handle people on their own, when the care plan clearly stated people required two staff to complete this safely. They explained two staff were not always available and if they did not assist people, they would be left in soiled clothes and beds.
- Relatives did not always feel involved in the day to day running of the home. Relatives told us

communication was poor and they were not kept informed of issues or general welfare of their loved ones. Following our inspection the provider arranged meetings with relatives and sent out questionnaires to receive feedback.

● People did not receive care and support that was person centred. Support we observed was task orientated and not individualised. The providers quality monitoring systems had not picked this up.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider understood the duty of candour. We saw they predominantly fulfilled their legal responsibilities. However, some relatives and staff told us that the management were not always open when things go wrong. For example, they did not follow up on concerns raised, but when questioned said they had been resolved and outcomes shared. This was not the feedback we received from staff and relatives who had raised concerns.

Working in partnership with others

● The provider engaged with healthcare professionals. We found that advice was sought when people's needs changed. However, we found this advice was not always followed.

The above indicates systems in place to monitor and improve the quality of the service were not effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received person-centred care that met their needs. Regulation 9 (1) (a) (b) (c) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure they were working within the principles of the Mental Capacity Act. Regulation 11 (1) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people, failed to ensure the proper and safe management of medicines and failed to ensure the proper and safe infection, prevention and control. Regulation 12 (1) (2) (a) (b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient

Treatment of disease, disorder or injury

numbers of suitably competent, skilled and experienced staff were deployed to meet people's needs.

Regulation 18 (1) (2) (a) (c)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the systems in place to monitor and improve the quality of the service were effective. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We have issued a warning notice